DOCKET

SHOW PROCEEDINGS AND ORDERS DATE: [12/21/89]

CASE NBR: [88100790] AFX STATUS: [ ]
SHORT TITLE: [Turnock, Bernard, et al.]
VERSUS [Ragsdale, Richard M., et al.] DATE DOCKETED: [111088]
PAGE: [01]

DATE	NOTE	PROCEEDINGS & ORDERS
Nov 10 1988		Statement as to jurisdiction filed.
Nov 10 1988		Appendix of appellant Turnock, et al. filed.
Dec 1 1988		Order extending time to file response to jurisdictional statement until January 14, 1989.
Jan 13 1989		Motion of appellee Richard M. Ragsdale to dismiss or affirm filed.
Jan 18 1989		DISTRIBUTED. February 17, 1989
Jan 27 1989		Reply brief of appellants Turnock, et al. filed.
Feb 21 1989		REDISTRIBUTED. February 24, 1989
Jun 23 1989		REDISTRIBUTED. June 29, 1989.
Jul 3 1989		Further consideration of the question of jurisdiction is POSTPONED to the hearing of the case on the merits.
		**********
Jul 27 1989		Order extending time to file brief of appellant on the merits until August 31, 1989.

SHOW PROCEEDINGS AND ORDERS DATE: [12/21/89]

CASE NBR: [88100790] AFX STATUS: [ ]
SHORT TITLE: [Turnock, Bernard, et al.]
VERSUS [Ragsdale, Richard M., et al.] DATE DOCKETED: [111088]
PAGE: [02]

DATE	NOTE	PROCEEDINGS & ORDERS
Aug 3 1989		Brief amicus curiae of American Family Assn. and Legal Action for Women filed.
Aug 16 1989		Motion of Alan Ernest for leave to represent children unborn and born alive filed.
Aug 16 1989		Motion of Legal Defense for Unborn Children for leave to file a brief as amicus curiae filed.
Aug 24 1989		Record filed.
Aug 28 1989		Brief amicus curiae of James Joseph Lynch, Jr. filed.
Aug 28 1989		Motion of Larry Joyce for leave to participate in oral argument as amicus curiae, for divided argument and for additional time for oral argument filed.
Aug 29 1989		Brief amicus curiae of Larry Joyce filed.
Aug 30 1989		Brief amici curiae of Hon. Christopher H. Smith, et al. filed. VIDED.
Aug 30 1989		Brief amicus curiae of American Academy of Medical Ethics

CASE NBR: [88100790] AFX STATUS: [ ]
SHORT TITLE: [Turnock, Bernard, et al.]
VERSUS [Ragsdale, Richard M., et al.] DATE DOCKETED: [111088]

DATE	NOTE	PROCEEDINGS & ORDERS
Aug 30 1989		Brief amicus curiae of American Academy of Medical Ethics filed. VIDED.
Aug 30 1989		Brief amicus curiae of National Right to Life Committee, Inc. filed. VIDED.
Aug 30 1989		Brief amicus curiae of Karen Bovik filed.
Aug 31 1989		Brief amici curiae of Rutherford Institute, et al. filed.
Aug 31 1989		Brief amicus curiae of United States Catholic Conference filed.
Aug 31 1989		Brief amici curiae of Certain Illinois Senators and Representatives filed.
Aug 31 1989		Brief amici curiae of Feminists For Life Of America, et al. filed.
Aug 31 1989		Brief amicus curiae of Focus On The Family And Family Research Council filed.
Aug 31 1989		Brief amicus curiae of National Right to Life Committee,

SHOW PROCEEDINGS AND ORDERS DATE: [12/21/89]

CASE NBR: [88100790] AFX STATUS: [ ]
SHORT TITLE: [Turnock, Bernard, et al.]
VERSUS [Ragsdale, Richard M., et al.] DATE DOCKETED: [111088]

DATE	NOTE	PROCEEDINGS & ORDERS
Aug 31 1989		Brief amicus curiae of National Right to Life Committee, Inc. filed. VIDED.
Aug 31 1989		Joint appendix filed.
Aug 31 1989		Brief of appellants Bernard J.Turnock, et al. filed.
Aug 31 1989		Brief amicus curiae of Free Speech Advocates filed.
Aug 31 1989		Brief of Catholics United For Life, et al. filed.
Sep 1 1989		Record filed.
Sep 7 1989		Brief amici curiae of Anti-Defamation League of B'Nai B'Rith, et al. filed. VIDED.
Sep 19 1989		Order extending time to file brief of appellee on the merits until October 14, 1989.
Sep 26 1989		SET FOR ARGUMENT TUESDAY, DECEMBER 5, 1989. (1ST CASE)
Oct 2 1989		Motion of Alan Ernest for leave to represent children unborn and born alive DENIED. Justice Stevens OUT.
Oct 2 1989		Motion of Legal Defense for Unborn Children for leave to

SHOW PROCEEDINGS AND ORDERS DATE: [12/21/89]

CASE NBR: [88100790] AFX STATUS: [ ]
SHORT TITLE: [Turnock, Bernard, et al.]
VERSUS [Ragsdale, Richard M., et al.] DATE DOCKETED: [111088]

DATE	NOTE	PROCEEDINGS & ORDERS
Oct 2 1989		Motion of Legal Defense for Unborn Children for leave to file a brief as amicus curiae DENIED. Justice Stevens OUT.
Oct 2 1989		Motion of Larry Joyce for leave to participate in oral argument as amicus curiae, for divided argument and for additional time for oral argument DENIED. Justice Stevens OUT.
Oct 4 1989		Record filed.
Oct 10 1989		Brief amici curiae of Committees on Civil Rights, et al.
Oct 13 1989		Brief amici curiae of Attorneys General of the States of Alaska, et al. filed.
Oct 13 1989		Brief amici curiae of National Abortion Federation, et al. filed.
Oct 13 1989		Brief amici curiae of Senators Bob Packwood, et al. filed.

SHOW PROCEEDINGS AND ORDERS DATE: [12/21/89]

CASE NBR: [88100790] AFX STATUS: [ ]
SHORT TITLE: [Turnock, Bernard, et al.]
VERSUS [Ragsdale, Richard M., et al.] DATE DOCKETED: [111088]

DATE	NOTE	PROCEEDINGS & ORDERS
Oct 13 1989		Brief amici curiae of American College of Obstetricians and Gynecologists, et al. filed.
Oct 14 1989		Brief amicus curiae of 274 Organizations in Support of Roe v. Wade filed. VIDED.
Oct 14 1989		Brief amici curiae of Madeleine Kunin, Governor of Vermont, et al. filed.
Oct 14 1989		Brief amicus curiae of Certain Illinois Senators and Representatives filed.
Oct 16 1989		Brief of appellees Richard M. Ragsdale, et al., and appendix filed.
Oct 17 1989		CIRCULATED.
Nov 15 1989		Reply brief of appellants Turnock, et al. filed.
Nov 22 1989		Motion of the parties to defer further proceedings in this case filed.
Nov 24 1989		DISTRIBUTED. DEC. 1, 1989. (Joint motion to defer

Last page of docket
SHOW PROCEEDINGS AND ORDERS DATE: [12/21/89]

CASE NBR: [88100790] AFX STATUS: [ ]
SHORT TITLE: [Turnock, Bernard, et al.]
VERSUS [Ragsdale, Richard M., et al.] DATE DOCKETED: [111088]

DATE	NOTE	PROCEEDINGS & ORDERS
Nov 24 1989		DISTRIBUTED. DEC. 1, 1989. (Joint motion to defer consideration of the appeal).
Dec 1 1989		Motion of the parties to defer further proceedings in this case GRANTED. Justice Stevens OUT.

JURISDICTIONAL

STATEMENT

No. 88-790

Supreme Court, U.S.
FILED
NOV 10 1988
JOSEPH F. SPANIOL, JR.
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, et al.,

Appellants,

v.

RICHARD M. RAGSDALE, M.D., et al.,

Appellees.

On Appeal From The United States Court Of Appeals For The Seventh Circuit

JURISDICTIONAL STATEMENT

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QUESTIONS PRESENTED

1. Whether Illinois can constitutionally license and regulate outpatient surgical facilities in which pregnancy terminations are performed to the same extent it licenses and regulates outpatient surgical facilities in which pregnancy terminations are not performed.

2. Whether a case or controversy existed with respect to the challenged statutes and regulations which were not being enforced by the State of Illinois prior to the filing of the complaint.

3. Whether statutes and regulations establishing standards for the construction, maintenance and operation of outpatient surgical facilities are constitutional as applied to outpatient surgical facilities in which pregnancy terminations are performed.

4. Whether the federal courts can refuse to give effect to severability requirements, thereby invalidating statutory and regulatory provisions which are constitutional.

PARTIES TO THE PROCEEDINGS

The defendants in the district court were Bernard J. Turnock, M.D., M.P.H., Director of the Illinois Department of Public Health; Neil F. Hartigan, Attorney General of Illinois; Gary L. Clayton, the Director of the Illinois Department of Registration and Education; and Richard M. Daley, State's Attorney of Cook County. Turnock, Hartigan and Clayton were the appellants in the court of appeals. Daley did not file a notice of appeal.

In addition, appellant Stephen F. Selcke, Director of the Illinois Department of Professional Regulation, is the successor in public office to Gary L. Clayton, Director of the Illinois Department of Professional Regulation.

The plaintiffs in the district court and appellees in the court of appeals were Richard M. Ragsdale, M.D., Margaret Moe, Northern Illinois Women's Center, Sarah Roe and Jane Doe.

TABLE OF CONTENTS

	PAGE
QUESTIONS PRESENTED	i
PARTIES TO THE PROCEEDINGS	ii
TABLE OF CONTENTS	iii
TABLE OF AUTHORITIES	vi
OPINIONS BELOW	1
JURISDICTION	1
CONSTITUTIONAL, STATUTORY AND REGULATORY PROVISIONS INVOLVED	2
STATEMENT OF THE CASE	4
The State Statutes	5
The Evidence Presented	6
Abortion Procedures	8
Enforcement Policies	9
The ASTC Regulations	11
Building Design and Construction Requirements	13
The Constitutional Challenge	14
THE QUESTIONS PRESENTED ARE SUBSTANTIAL	21
A. THE COURT ERRONEOUSLY ASSUMED JURISDICTION OVER CERTAIN CHALLENGED PROVISIONS WHICH WERE NOT BEING ENFORCED	21

B. THE MAJORITY OPINION ERRONEOUSLY FOUND THAT THE CHALLENGED STATUTES AND REGULATIONS VIOLATE THE CONSTITUTIONAL RIGHT TO PRIVACY 24

C. THE MAJORITY OPINION CONFLICTS WITH DECISIONS OF THIS COURT REGARDING SEVERANCE OF PURPORTEDLY UNCONSTITUTIONAL PROVISIONS . 28

CONCLUSION 30

APPENDIX

(Separate Volume)

APP. PAGE

A—Slip Opinion of the United States Court of Appeals for the Seventh Circuit, March 10, 1988 1

B—Judgment of the United States Court of Appeals for the Seventh Circuit, March 10, 1988 . 102

C—Order of the United States Court of Appeals for the Seventh Circuit Amending the Slip Opinion, April 13, 1988 103

D—Amended Order of the United States Court of Appeals for the Seventh Circuit Denying the Petition for Rehearing and Suggestion for Rehearing *En Banc*, August 16, 1988 105

E—Order of the United States Court of Appeals for the Seventh Circuit Denying the Petition for Rehearing and Suggestion for Rehearing *En Banc*, August 12, 1988 107

F—Class Certification and Preliminary Injunction Order of the United States District Court for the Northern District of Illinois, Eastern Division, December 11, 1985 109

G—Memorandum Opinion and Order of the United States District Court for the Northern District of Illinois, Eastern Division, November 27, 1985 112

H—Notice of Appeal, November 7, 1988 146

I— Ambulatory Surgical Treatment Center Act, 111½ Ill. Rev. Stat. ¶¶ 157-8.1, *et seq.* 149

J— Health Facilities Planning Act, 111½ Ill. Rev. Stat. ¶¶ 1151, *et seq.* 166

K—Medical Practice Act, 111 Ill. Rev. Stat. ¶ 4400-22 193

L—77 Illinois Administrative Code, Chapter 1, § 205, Subchapter b 203

TABLE OF AUTHORITIES

Cases	PAGE(S)
Abortion Coalition of Mich., Inc. v. Mich. Dep't of Public Health, 426 F.Supp. 471 (E.D. Mich. 1977)	26
Arcara v. Cloud Books, Inc., 478 U.S. 697 (1986)	26
Baird v. Department of Public Health, 599 F.2d 1098 (1st Cir. 1979)	25
Buckley v. Valeo, 424 U.S. 1 (1976)	29
Champlin Refining Co. v. Corporation Commission, 286 U.S. 210 (1932)	29
Charles v. Carey, 579 F.Supp. 464 (N.D. Ill. 1983)	10
C.I.O. v. McAdory, 325 U.S. 472 (1945)	23
City of Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416 (1983)	10, 15, 24
City of Renton v. Playtime Theatres, Inc., 475 U.S. 41 (1986)	26
Connecticut v. Menillo, 423 U.S. 9 (1975)	24
El Paso & Northeastern R. Co. v. Gutierrez, 215 U.S. 87 (1909)	29
Green v. Mansour, 474 U.S. 64 (1985)	23
Hodgson v. Lawson, 542 F.2d 1350 (8th Cir. 1976)	25
International Harvester Co. v. Deere & Co., 623 F.2d 1207 (7th Cir. 1980)	23
J.N.S., Inc. v. State of Ind., 712 F.2d 303 (7th Cir. 1983)	23

Minneapolis Star & Tribune Co. v. Minn. Comm'n of Revenue, 460 U.S. 575 (1983)	26
Planned Parenthood Ass'n v. Ashcroft, 462 U.S. 476 (1983)	10, 27
Poe v. Ullman, 367 U.S. 497 (1961)	23
Regan v. Time, Inc., 468 U.S. 641 (1984)	29
Roe v. Wade, 410 U.S. 113 (1973)	15, 18, 19, 24
Simopoulos v. Virginia, 462 U.S. 506 (1983)	10
Thornburgh v. American College of Obstetricians, 476 U.S. 747 (1986)	19
Village of Oak Lawn v. Marcowitz, 86 Ill.2d 406 (1981)	9, 10, 28
Watkins v. Blinzinger, 789 F.2d 474 (7th Cir. 1986)	23
Westchester Women's Health Org. v. Whalen, 475 F.Supp. 734 (S.D.N.Y. 1979)	25, 26

Constitutional Provisions

U.S. Const. Amend. I	2, 5
U.S. Const. Amend. IV	3, 5
U.S. Const. Amend. V	3, 5
U.S. Const. Amend. IX	3, 5
U.S. Const. Amend. XI	3, 23
U.S. Const. Amend. XIV, Section 1	3, 4, 5

Statutes

28 U.S.C. Section 1343 1

28 U.S.C. Section 2201 1

28 U.S.C. Section 2202 1

42 U.S.C. Section 1983 1

Ambulatory Surgical Treatment Center Act, Ill. Rev. Stat. ch. 111½, pars. 157-8.1 *et seq.* .. .. *passim*

Health Facilities Planning Act, Ill. Rev. Stat. ch. 111½, pars. 1151 *et seq.* .. *passim*

Medical Practice Act, Ill. Rev. Stat. ch. 111, par. 4400-22 ..... *passim*

Regulations

Ambulatory Surgical Treatment Center Licensing Requirements, 77 Ill. Adm. Code, Ch. 1, Section 205, Subchapter 6 ..... *passim*

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, et al.,

Appellants,

v.

RICHARD M. RAGSDALE, M.D., et al.,

Appellees.

On Appeal From The United States Court Of Appeals For The Seventh Circuit

JURISDICTIONAL STATEMENT

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Seventh Circuit entered March 10, 1988 is reported at 841 F.2d 1358 (7th Cir. 1988) and is reproduced at Appendix A. On August 12, 1988 the defendants' petition for rehearing and suggestion for rehearing en banc was denied. (Appendix D, E). The memorandum opinion of the United States District Court for the Northern District of Illinois rendered November 27, 1985 is reported at 625 F.Supp. 1212 (N.D. Ill. 1985) and is reproduced at Appendix G.

The judgment order of the United States District Court entered December 11, 1985 is not reported, but is reproduced at Appendix F.

JURISDICTION

This action, brought under 28 U.S.C. Sections 2201 and 2202 and 42 U.S.C. Section 1983 challenges the constitutionality of portions of the Illinois Medical Practice Act, Ambulatory Surgical Treatment Center Act, and Health Facilities Planning Act. Invoking the jurisdiction of the District Court under 28 U.S.C. Section 1343 plaintiffs filed a class action seeking declaratory and injunctive relief. Subsequent to an evidentiary hearing, the District Court entered on November 27, 1985 and December 11, 1985 a preliminary injunction in favor of plaintiffs and enjoined enforcement of the Acts and rules promulgated thereunder to the extent any person or facility offers or performs, or desires to offer or perform first and/or early second

trimester abortions or other abortion-related gynecological procedures.

On appeal, the United States Court of Appeals for the Seventh Circuit vacated as moot one portion of the District Court's decision, held unconstitutional the other challenged provisions, and affirmed the remainder of the decision. Its judgment was entered on March 10, 1988.

On August 12, 1988 a majority of the members of the original panel voted to deny the defendants' petition for rehearing, and the suggestion for rehearing en banc failed by an equally divided court. Judges Wood, Posner, Coffey, Manion, and Kanne voted to grant rehearing en banc. (Appendix D, E).

Defendants Turnock, Hartigan and Selcke filed their Notice of Appeal in the Court of Appeals on November 7, 1988. (Appendix H). Jurisdiction of the Supreme Court of the United States to review this judgment by appeal is conferred by 28 U.S.C. Section 1254(2).

CONSTITUTIONAL, STATUTORY AND REGULATORY PROVISIONS INVOLVED

Constitutional Provisions

U.S. Const. Amend. I:

> Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.

U.S. Const. Amend. IV:

> The right of the people to secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the person or things to be seized.

U.S. Const. Amend. V:

> No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

U.S. Const. Amend. IX:

> The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.

U.S. Const. Amend. XI:

> The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State.

U.S. Const. Amend. XIV, Section 1:

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any

person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

State Statutes

Ambulatory Surgical Treatment Center Act,
Ill. Rev. Stat. ch. 111½, pars. 157-8.1 *et seq.*
(Reprinted at Appendix I)

Health Facilities Planning Act,
Ill. Rev. Stat. ch. 111½, pars. 1151 *et seq.*
(Reprinted at Appendix J)

Medical Practice Act,
Ill. Rev. Stat. ch. 111, par. 4400-22
(Reprinted at Appendix K)

Regulations

Ambulatory Surgical Treatment Center
Licensing Requirements, 77 Ill. Adm. Code, Ch. 1,
Section 205, Subchapter b
(Reprinted at Appendix L)

STATEMENT OF THE CASE

Plaintiff Ragsdale is a medical doctor licensed in Illinois, who performs abortions as part of his medical practice. Plaintiff Northern Illinois Women's Center is an Illinois corporation which provides abortion services to women in Rockford, Illinois. Plaintiff Margaret Moe is a registered nurse and the sole owner of a medical facility in Cook County, Illinois. Plaintiffs Sarah Roe and Jane Doe are female citizens of child-bearing age who had abortions in the past and may seek abortions in the future.

Plaintiffs claimed that the challenged statutes form a tripartite regulatory scheme which impermissibly restricts

the performance of first and second trimester abortions. Specifically, plaintiffs alleged that the challenged statutes and regulations were violative of rights secured by the First, Fourth, Fifth, Ninth and Fourteenth Amendments to the United States Constitution. Plaintiffs contended that the "scheme" as applied singles out for discriminatory treatment facilities in which abortions are performed and substantially inhibits a woman from exercising her right to choose to have an abortion under medically safe and reasonably inexpensive conditions. Plaintiffs further averred that the challenged "scheme" impermissibly prevented physicians from implementing a woman's decision to choose abortion in that the "scheme" mandated that physicians and facilities comply with allegedly irrational and arbitrary requirements. (Compl., pars. 1-4).

On September 20, 1985 plaintiff Richard M. Ragsdale, M.D. filed a motion for preliminary injunction asking the district court to enjoin defendants from enforcing the challenged statutes and regulations. Plaintiff Ragsdale claimed that unless the statutes and regulations were enjoined he would be unable to perform abortion services after December 31, 1985.

The State Statutes

The Ambulatory Surgical Treatment Center Act [hereinafter ASTC Act] became law in 1973. (Appendix I). The stated purpose of the ASTC Act is to provide for the protection of the public health through the establishment and enforcement of standards for the construction and operation of ASTCs. ASTCs by definition are facilities which are primarily devoted to the performance of surgical procedures.[1]

[1] In addition to ASTCs, the Illinois Department of Public Health is responsible for licensing and surveying numerous other facilities

(Footnote continued on following page)

The Illinois Health Facilities Planning Act [HFP Act] became law in 1974. (Appendix J). The purpose of the HFP Act is to attempt to obtain a comprehensive health care delivery system involving all types of health care facilities, services and equipment. The HFP Act also represents an attempt to restrain the rising costs of health care by preventing unnecessary construction and duplication of unneeded health care facilities. (App. 166). Types of health care facilities included within the HFP Act's provisions include those licensed pursuant to the Health Maintenance Organization Act, the ASTC Act, the Nursing Home Care Reform Act of 1979, the Hospital Licensing Act, and kidney disease treatment centers. (App. 167).

The Medical Practice Act [MPA] provides the licensure requirements of physicians in Illinois and prohibits the practice of medicine by any person not holding a valid license. Ill. Rev. Stat. ch. 111, par. 4401 *et seq.* (1983). Now, par. 4400-1 *et seq.* of the Medical Practice Act of 1987. (Appendix K).

The Evidence Presented

At the time of trial, there were 42 licensed ASTCs in Illinois. The types of surgical procedures performed in licensed ASTCs include plastic surgery, removal of cysts and tumors, pregnancy terminations, tubal ligations, hernia repairs and rhinoplasty repairs of the nose. Some surgical procedures performed in ASTCs, including abortions, are done so under a general anesthesia. Of the 42 licensed

[1] *continued*
which provide health or medical services. These facilities include blood banks, clinical laboratories, alcohol treatment centers, hospitals, hospices, and nursing homes. Ill. Rev. Stat. ch. 111½, pars. 601-101 *et seq.*; 621-101 *et seq.*; 2301 *et seq.*; 142 *et seq.*; 6101 *et seq.*; and 4151-101 *et seq.*

ASTCs, 22 indicated that some pregnancy terminations would be performed.

For the 12 years prior to trial Dr. Ragsdale was the primary abortion provider in northwestern Illinois. Dr. Ragsdale is well known as a provider of abortion services in the Rockford area. In 1973 Dr. Ragsdale opened the plaintiff Northern Illinois Women's Center. The Center primarily provides first and early second trimester abortion services. Dr. Ragsdale performs approximately 3500 abortions per year at his facility. In the 12 years prior to trial, Dr. Ragsdale had performed in excess of 42,000 abortions.

At the time of trial, Dr. Ragsdale's facility had been licensed as an ASTC in Illinois for 12 years. The facility contained variations from the ASTC regulations. Any such variances had not substantially affected renewal of Dr. Ragsdale's license for those 12 years. Dr. Ragsdale was then informed by his landlord that his lease would not be renewed. The nonrenewal of the lease was a result of the landlord's decision to expand and renovate its building and desire to have as tenants doctors who admitted patients to Rockford Memorial Hospital. Dr. Ragsdale therefore planned to move his facility. The Illinois Department of Public Health preliminarily approved his plans for relocation. In addition, Dr. Ragsdale submitted an application for a certificate of need.

On March 14, 1985 Comprehensive Health Planning of Northern Illinois (CHPNI) held a public meeting regarding the proposed relocation. CHPNI is a federally funded organization which is a separate entity from the HFP Board. It is responsible for completing an independent review of a proposed project.

Dr. Ragsdale attended the CHPNI meeting. There were in Dr. Ragsdale's opinion some "rational" discussions at

the meeting, and some statements supporting the need issue. There were, in addition, more statements that there was no need for the facility. The meeting then degenerated into a shouting match over abortion.

Dr. Ragsdale was subsequently informed by CHPNI that his proposal met the review requirements, including the need requirement. However, the lease which Dr. Ragsdale had procured was withdrawn by the lessor.

In order to aid his testimony at trial, Dr. Ragsdale determined what it would cost on a rough basis and in broad terms to comply with the ASTC Act and regulations at his new facility. Dr. Ragsdale first estimated the cost of relocation of his practice as a result of the loss of his lease, and without complying with the ASTC Act and regulations. Dr. Ragsdale concluded that the cost would be an additional $22.45 per patient per year.

Dr. Ragsdale also prepared an estimate which represented his guess as to what it would cost in addition to the $22.45 in order to bring his new facility into "reasonable compliance" with the ASTC regulations. Dr. Ragsdale estimated that the cost would be an additional $22.21 per patient per year.

Abortion Procedures

It is uncontroverted that abortions are surgical procedures. According to the plaintiffs' expert witnesses, there are few surgical procedures given so little attention and so underrated in its potential hazard as abortion. It is also agreed that all physicians licensed under the MPA do not have the qualifications, training and experience to perform safe first and early second trimester abortions.

Plaintiffs' expert maintained that medical education in this country has paid little attention to abortion services.

Abortions, more than any other types of procedures, require much experience and practice. It is not a procedure which can be done well after a few hundred or even a few thousand procedures.

There are several factors which affect the safety of first trimester and early second trimester abortion procedures. One factor is the skill, experience and professional integrity of the physician performing the abortion. Other factors include the duration of the pregnancy; choice of abortion technique; the existence of sterile conditions; the availability of qualified staff and appropriate equipment; the availability of emergency facilities; and the type of anesthesia which is used.

Enforcement Policies

In 1981, the Supreme Court of Illinois rendered its decision in *Village of Oak Lawn v. Marcowitz*, 86 Ill.2d 406 (1981). In *Marcowitz* the court considered a village ordinance which had adopted the definition of an ASTC that was found in the State ASTC Act. The Supreme Court of Illinois held that the ordinance was unconstitutional to the extent that it defined an ASTC to be any facility in which abortions are performed, irrespective of whether devoted primarily to that purpose. *Marcowitz*, 86 Ill.2d at 420. The court then severed that portion of the definition of an ASTC from the remainder of the ordinance.

Four days after *Marcowitz* was decided, the Illinois Department of Public Health, pursuant to a written policy, ceased to enforce the identical abortion specific portion of the definition of an ASTC found in the State statute. Since 1981, therefore, licensure and enforcement proceedings were applicable only to those facilities primarily devoted to the performance of surgical procedures.

In 1982, United States District Judge Charles P. Kocoras enjoined the Illinois Department of Public Health from enforcing Section 4 of the Illinois Abortion Law of 1975 and "any related regulation." Section 4 was a second trimester hospitalization requirement. The Department interpreted this ruling as also enjoining the enforcement of ASTC Regulation Section 205.740 which prohibited the performance of second trimester abortions in ASTCs. (App. 222).

In 1983, this Court decided the cases of *City of Akron v. Akron Center For Reproductive Health, Inc.*, 462 U.S. 416 (1983); *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476 (1983); and *Simopoulos v. Virginia*, 462 U.S. 506 (1983). The decision in *Akron* reinforced the earlier order, and the Department's policy of not enforcing Section 205.740 of the Regulations therefore continued.

In December of 1982 or January of 1983 Dr. Ragsdale was informed that Section 205.740 of the ASTC Regulations was no longer being enforced. As a result, Dr. Ragsdale began to perform second trimester abortions at his facility.

In 1983, in *Charles v. Carey*, 579 F.Supp. 464 (N.D. Ill. 1983), Section 10 of the Illinois Abortion Law of 1975 (the reporting requirement) was permanently enjoined. As a result Section 205.760 (App. 223), an abortion specific reporting requirement of the ASTC Regulations was no longer enforced. Dr. Ragsdale was informed that this section was no longer being enforced.

The Illinois Department of Registration and Education (now Department of Professional Regulation) has absolute prosecutorial discretion in the initiation of disciplinary actions under the Medical Practice Act. Because of the *Marcowitz* decision and other decisions concerning the abortion issue, the challenged portion of the MPA (App.

193) was not being enforced by the Department to restrict the performance of all abortions to licensed facilities.

The evidence submitted regarding the State's enforcement policies in light of various decisions was not controverted.

The ASTC Regulations

There are a total of 59 ASTC Regulations (excluding subsections). Of that total very few are abortion specific. Of the abortion specific regulations, as previously noted, two were not being enforced prior to the filing of plaintiffs' complaint.

Plaintiffs' experts testified generally that the ASTC regulations were not medically necessary for the performance of a safe first or early second trimester abortion. Certain components of the regulations, however, were acknowledged to be consistent with safe and acceptable standards of medical care. Moreover, some regulations were described as belaboring the obvious, the kind of thing any competent practitioner would do, and superfluous.

For example, Section 205.240 of the regulations provides that the ASTC is to formulate a written policies and procedures manual. (App. 213). Dr. Ragsdale described this requirement as standard medical and administrative practice.

Likewise, Section 205.230(a) of the regulations provides that the management of a licensed ASTC is to appoint a qualified consulting committee. (App. 211). Dr. Ragsdale testified that this regulation is "belaboring the obvious."

Similarly, the plaintiffs' expert testified that either the medical director or principal physician of an abortion facility should have staff privileges at the nearest hospital, or there should be a hospital transfer agreement. Section

205.540(c) of the regulations provides that there should be written documentation of either a transfer agreement, a statement that the medical director has admitting privileges, or that each staff physician, podiatrist or dentist has admitting privileges. (App. 218).

Subpart G of the regulations sets forth additional requirements for facilities in which obstetrical/gynecological procedures are performed. (App. 220-23). This section applies to abortions as well as other gynecological and obstetric procedures. Plaintiffs' expert testified that there are aspects of Subpart G which are consistent with good standards of medical practice.

The American College of Obstetricians and Gynecologists' Standards for Obstetric-Gynecologic Services, Sixth Edition [ACOG standards], provide that ambulatory care facilities for abortion services should meet the same standards of care as for other surgical procedures. Section 205.710 of the ASTC regulations contains an essentially identical provision. (App. 220). The parties' expert witnesses agreed with this provision.

Likewise, plaintiffs' expert testified that counseling is an indispensable part of a thorough preoperative evaluation and preparation of a patient for an abortion procedure, and that counseling should include a discussion of the alternatives for dealing with pregnancy. Section 205.730(b) of the regulations provides that counseling is to be provided prior to obstetrical/gynecological procedures following diagnosis of pregnancy. (App. 221).

It is agreed that routine laboratory work for abortion procedures should include a urine screening exam for pregnancy, a hematocrit or hemoglobin, an Rh screening test, dip stick urinalysis and for black patients a sickle cell test. Section 205.520(b) of the regulations simply provides that a hemoglobin or hematocrit is to be performed prior to

certain surgical procedures. (App. 216-17). Section 205.730(a) provides that prior to obstetrical procedures blood Rh factor is to be determined and that prior to performing an abortion procedure the diagnosis of pregnancy is to be established. (App. 221).

It is similarly agreed that after every abortion, removed tissue should be examined. One of the purposes of the pathology report is to confirm pregnancies in early stages. Another purpose is to ensure that fetal parts are present and to be able to alert patients to the possibility of an ectopic pregnancy. Section 205.530(c) of the ASTC regulations merely provides that all tissues removed during surgery are to be examined by a consulting pathologist. (App. 217).

Building Design and Construction Requirements

Subparts (I) and (J) of the ASTC regulations set forth various building design, construction standards, and physical and mechanical requirements. (App. 225-44). Plaintiffs' expert, who did not consider himself a building design, construction, or mechanical expert testified that the provisions of Subparts (I) and (J) are not medically necessary for the operation of a facility in which first and early second trimester abortions are to be performed. The defendants introduced evidence demonstrating that many of these regulations reflect common, accepted and standard practices.

For example, Section 205.1510 of the regulations provides that after building heating, ventilating and air conditioning systems are installed they shall be tested and balanced to ensure that they are in proper working condition. (App. 240). The regulation also provides that upon completion of the facility, the owner of the ASTC is to be provided with operating and maintenance instructions.

Section 205.1520 provides, among other things, for insulation in the facility and in certain situations for a flame spread rating in accordance with the National Fire Protection Association. (App. 240-41). These requirements were described as standard for health facilities.

Similarly, various regulations dealing with hot water systems, ventilation systems, and plumbing fixtures were demonstrated to be standard requirements.

The Constitutional Challenge

The trial conducted by the district court was held on November 18-22 and 26, 1985. On November 27, 1985 and December 11, 1985 the district court entered orders granting Dr. Ragsdale's motion for preliminary injunction.

In the November 27, 1985 Order, the district court found that plaintiffs had prevailed on all four traditional factors the courts must consider in ruling on a motion for preliminary injunction. (App. 129). First, the district court decided that plaintiffs would suffer irreparable harm without an injunction and that no adequate remedy at law existed. Specifically, it found that the challenged statutes and regulations have the effect of raising the cost and limiting the availability of abortions. (App. 129). In addition, the district court found that the challenged provisions (1) force complying facilities to raise their fees, possibly beyond the economic means of some women; (2) discourage other non-complying facilities from offering abortion services; and (3) make it difficult, if not impossible, for current abortion facilities to move or new abortion facilities to be constructed. (App. 130). Further, the district court rejected defendants' argument that plaintiffs could not be irreparably harmed by those statutes and regulations which are not being enforced. (App. 133).

Next, the district court determined that the threatened harm to plaintiffs outweighed any possible harm to defendants. (App. 134).

Third, the district court considered the merits of plaintiffs' claims. It utilized the trimester standard established in *Roe v. Wade*, 410 U.S. 113 (1973), as interpreted in *City of Akron v. Akron Center for Reproductive Health*, 426 U.S. 416 (1983) and other cases, to provide the legal framework for the constitutional evaluation of the challenged statutes and regulations. (App. 134-35).

The district court noted that State regulations having no significant impact on a woman's exercise of her abortion right during the first trimester may be permissible where justified by important State health objectives. It held, however, that *Roe* does not stand for the proposition that general medical regulations which apply to the performance of first and early second trimester abortions are *per se* constitutional. (App. 136). Thus, the district court concluded that even general regulations which burden a woman's right to choose to terminate her pregnancy during the first trimester would have to meet the compelling governmental interest requirement. In addition, the district court decided that a regulation which burdens a woman's right to choose to terminate her pregnancy during the early second trimester must be reasonably related to the preservation and protection of maternal health. (App. 137).

Applying these standards to this case, the district court found that plaintiffs had demonstrated that the statutory and regulatory scheme places a burden on a woman's right to choose to terminate her pregnancy during the first and early second trimester. Specifically, it found that the challenged provisions (1) increase the cost and decrease the availability of abortions and (2) may delay the effectuation of a woman's decision to abort. (App. 137).

Further, the district court found that defendants had failed to produce any evidence of a compelling or even rational basis for the challenged statutes and regulations. It noted that defendants had shown that certain regulations are consistent with accepted medical practice, but that such showing is not equivalent to a demonstration that the challenged provisions are medically necessary. Thus, the district court found a reasonable likelihood that plaintiffs will succeed on the merits. (App. 137-38).

Lastly, the district court determined that the public interest would be served by the issuance of the preliminary injunction. (App. 139).

The defendants were preliminarily enjoined and restrained from enforcing the challenged provision of the Medical Practice Act (MPA); the Ambulatory Surgical Treatment Center Act (ASTC) and the rules and regulations promulgated thereunder; and the Health Facilities Planning Act (HFP): to the extent any person or facility offers or performs, or desires to offer or perform first and/or early second trimester abortions or other abortion-related gynecological procedures. (App. 110-11).

The district court also certified the following classes: (a) a plaintiff class of physicians and surgeons who perform or desire to perform abortions in Illinois; (b) a plaintiff class of all Illinois women of child-bearing age who desire or may desire an abortion sometime in the future; and (c) a defendant class of all State's Attorneys in Illinois. (App. 110).

On December 11, 1985 the district court orally clarified portions of its ruling. The district court specified that the Illinois Department of Public Health is not enjoined from regulating ASTCs in which abortions are performed or desired to be performed to the extent that such ASTCs are performing surgical procedures other than abortions.

In addition, the district court specified that in deciding whether a health care facility was devoted primarily to the performance of surgical procedures, and therefore required to be licensed under the ASTC Act, the Illinois Department of Public Health is not prohibited from counting the number of abortion procedures performed in the facility. The Department cannot, however, enforce the regulations as to the abortion procedures performed—but can enforce the regulations as to other procedures performed at the facility.

Defendants appealed from the district court's orders to the United States Court of Appeals for the Seventh Circuit. On March 10, 1988 that court rendered its decision in this matter. (App. 1). The majority opinion affirmed, with one exception, the district court's entry of a preliminary injunction. The exception is the challenge to one ASTC regulation—a second trimester hospitalization requirement—which the majority held was not being enforced, was moot, and should have been dismissed. Judge Coffey submitted a lengthy dissent from the majority opinion. (App. 34-80).

The majority opinion first considered whether certain of plaintiffs' challenges have been mooted by the State's policy of nonenforcement. It noted that the voluntary cessation of putatively illegal conduct ordinarily will not moot a controversy and prevent its adjudication by a federal court. (App. 10-11). Further, the majority stated that such cessation does render a controversy moot when there is no reasonable expectation that the putatively illegal conduct will be repeated and that there are no remaining effects of the alleged violation. (App. 11).

Applying these principles to this case, the majority found the challenge to the second trimester hospitalization requirement is moot because enforcement ceased in

1983. (App. 11-13). It held, however, that the challenge to the reporting requirement of the ASTC Act and regulations is not moot because the State did not produce pre-existing documentation of the nonenforcement policy. (App. 13). Finally, it held that the challenge to the application of the ASTC Act and regulations to first trimester abortions is not moot. It noted that those requirements were no longer applied to the occasional abortion provider, but that such requirements were applied to doctors who exclusively perform first trimester abortions. Further, the majority stated that the evidence on this point—testimony from the legal counsel for the state agency charged with enforcement authority that the challenged provision of the MPA was not being enforced—was too ambiguous. (App. 13-14).

In considering the merits of the case, the majority opinion, like the district court, relied upon the "trimester" approach of *Roe v. Wade*, 410 U.S. 113 (1973). (App. 15). It analyzed various decisions of this Court and stated that where first trimester abortions are involved, not only must the impact of the challenged regulations be insignificant in terms of the woman's exercise of her right, but also the regulation must be justified by important state health objectives. (App. 17).

The majority found that statement consistent with existing Seventh Circuit precedent which holds that once such regulations are shown to have more than a *de minimus* impact on the abortion decision, the government must show a compelling basis for the law, *i.e.*, that the burden is not undue or unjustifiable. (App. 17). Thus, the majority opinion concluded that the district court's application of a "medical necessity" standard was consonant with the legal framework applicable to this case. (App. 18). Further, the majority rejected defendants' argument that because the regulations apply to all facilities primarily devoted to surgery, those regulations should be reviewed under a different standard than if they had singled out abortions. (App. 21). In addition, it decided that the district court's findings that the challenged provisions substantially burden the effectuation of the abortion decision were not clearly erroneous. (App. 22).

The first facet of the challenged statutes and regulations which the majority considered was the requirement that facilities performing abortions be licensed. (App. 23). It held that under *Roe* the State may not require separate licensure of facilities primarily devoted to performing abortions during the first trimester. (App. 24). Once the licensing requirement falls, the majority reasoned that the remaining requirements fall with it. (App. 25).

Nevertheless, the majority considered and ruled upon the constitutionality of three abortion-specific regulations. First, it construed section 205.730(a)(2) (App. 221) to unconstitutionally require the physician who is to perform the abortion to also perform a pregnancy test, even if such test had previously been done by another physician. (App. 27). Second, the majority held that section 205.730(b)(3) (App. 221-22) invalidly requires counseling to include a discussion of alternatives, citing *Thornburgh v. American College of Obstetricians*, 476 U.S. 747 (1986). (App. 27). Third, it construed section 205.730(b)(2)(D) (App. 221) to unconstitutonally preclude the performing physician from providing the counseling. (App. 28-29).

The generally applicable regulations regarding physical plant, equipment, and staffing were also struck down by the majority. It concluded that those provisions impose a substantial burden and are not justified by health objectives. (App. 29-31).

In addition, the majority found the "certificate of need" proceeding of the Health Facilities Planning Act unconsti-

tutional. It held the State's interest in preventing wasteful duplication of resources to be insufficient in this context. (App. 31-32).

Finally, the majority rejected defendants' request to sever those provisions which were held unconstitutional. It reasoned that severance was not appropriate because the licensure provision had been invalidated. (App. 32). Further, it found that the challenged provisions were "so riddled with exceptions resulting from judicial decisions and nonenforcement policies as to be unintelligible." Under those circumstances, the majority found that it could not untangle the constitutional from the unconstitutional provisions. (App. 32-33).

The dissenting opinion finds that the States are authorized under *Roe* to apply the same licensing standards to abortion facilities as those applied to facilities performing similar surgical procedures. (App. 35). Under that standard, the dissent would enjoin and sever the challenged portion of the Medical Practice Act and the abortion specific language of par. 157-8.3(A) of the ASTC Act. (App. 38). It argues that the States are free to regulate ambulatory surgical treatment centers, including those performing abortions, as long as the abortions are not singled out from other, similar surgical procedures, subject to the rational basis test governing social and economic legislation. Under the rational basis test, moreover, the dissent finds the ASTC Act and IHFP Act constitutional. (App. 64). In evaluating the abortion-specific statutes and regulations under the strict scrutiny test, the dissent would uphold all provisions but one [section 205.730(b)(2)(D)]. (App. 73). The dissent finds that the challenged provisions neither burden the abortion decision or its effectuation and are justified by important health objectives. (App. 80).

THE QUESTIONS PRESENTED ARE SUBSTANTIAL

This appeal is of exceptional importance because the majority opinion, under the guise of protecting a woman's constitutional right to privacy, has exempted outpatient surgical facilities in which abortions are performed from general licensure and regulatory provisions. In so doing, the majority emasculates the duty and authority of the State of Illinois to protect the health, safety, and welfare of its citizens by licensing and regulating outpatient surgical facilities in which first or early second trimester abortions are performed in the same manner that other surgical facilities are regulated.

Further, the majority opinion is in conflict with decisions of this Court with respect to the jurisdictional issues presented in this case. The opinion is also in conflict with decisions of this Court and other courts of appeals with respect to the authority of the State to license and regulate outpatient surgical facilities in which abortions are performed. Finally, the refusal of the majority opinion to sever any purportedly unconstitutional provisions is in conflict with decisions of this Court.

A.

THE COURT ERRONEOUSLY ASSUMED JURISDICTION OVER CERTAIN CHALLENGED PROVISIONS WHICH WERE NOT BEING ENFORCED.

At trial, the defendants introduced evidence that due to various court decisions which pre-date the complaint in this matter, certain challenged provisions were not being enforced by the State. Those provisions are: the abortion specific language of par. 157-8.3 of the ASTC Act (App. 149-50); Section 205.740 (App. 222) (prohibition of

second trimester abortions in ASTCs) and 205.760 (App. 223) (abortion specific reporting requirement) of the ASTC Regulations; and par. 4400-22 of the MPA. (App. 193). This evidence was not contradicted.

Nonetheless, the majority held with respect to the reporting requirement of Section 205.760 that the State's position of nonenforcement is "asserted only in this litigation." This conclusion is clearly erroneous. The evidence reveals that this provision has not been enforced since 1983. With respect to the challenged provision of the MPA, the majority held that the evidence of nonenforcement is "equivocal." This conclusion is also erroneous. Legal counsel to the Department of Registration and Education (now Department of Professional Regulation) testified that based upon various decisions in the abortion area, this section was not being enforced. The plaintiffs did not introduce any evidence to the contrary.

The defendants argued below that in light of the policies of nonenforcement which were articulated by the regulatory agencies and entered into evidence, plaintiffs had not presented a justiciable controversy as to certain challenged provisions. However, the majority opinion utilized a mootness analysis with respect to those nonenforced provisions. The majority concluded that plaintiffs' challenge to the second trimester hospitalization requirement (ASTC Regulation Section 205.740) (App. 222) was moot. The challenges to the other unenforced provisions, however, were not found to be moot.

Preliminarily, however, a mootness analysis is not appropriate in this context. Mootness issues arise when a challenged policy changes after the commencement of litigation. Here, the enforcement policies are based on court decisions and determinations which pre-date this lawsuit.

It is axiomatic that the court must look to the state of affairs as of the filing of the complaint in determining

whether a justiciable controversy exists. *International Harvester Co. v. Deere & Co.*, 623 F.2d 1207, 1210 (7th Cir. 1980). Even where fundamental rights are allegedly involved, "a litigant must establish a more immediate threat than simply a general policy of enforcing laws." *J.N.S., Inc. v. State of Ind.*, 712 F.2d 303, 305 (7th Cir. 1983) (lack of justiciable controversy found in challenge by seller of sexually explicit materials to state civil RICO statutes). Thus, the courts should not pass on the constitutionality of challenged provisions which are not being enforced. *Poe v. Ullman*, 367 U.S. 497, 507 (1961) (lack of justiciable controversy found in challenge to prohibition against provision of contraceptive advice and use of contraceptive devices); *C.I.O. v. McAdory*, 325 U.S. 472, 475 (1945) (lack of justiciable controversy found in light of agreement not to enforce challenged state law).

The majority's assumption of jurisdiction over the unenforced provisions in this case is not only in conflict with the foregoing decisions regarding justiciability standards, but also with certain decisions governing the jurisdictional bar created by the Eleventh Amendment. That amendment limits the power of federal courts to grant relief in cases where there are no ongoing violations of federal law. *Green v. Mansour*, 474 U.S. 64, 71 (1985). That limitation is applicable even in those instances where mootness is at issue. *Watkins v. Blinzinger*, 789 F.2d 474, 484 (7th Cir. 1986). Thus, even if an underlying claim is not moot, the Eleventh Amendment bars further proceedings in federal court where there is no continuing conduct the State must change to comply with federal law. *Id.* Accordingly, the majority's assumption of jurisdiction over unenforced provisions is in conflict with decisions governing justiciability standards and with decisions dealing with Eleventh Amendment standards because there is no ongoing violation of federal law.

B.

THE MAJORITY OPINION ERRONEOUSLY FOUND THAT THE CHALLENGED STATUTES AND REGULATONS VIOLATE THE CONSTITUTIONAL RIGHT TO PRIVACY.

The majority opinion affirmed the district court's exemption of abortion procedures from the licensure and regulatory provisions which generally apply to outpatient surgical facilities. In addition, the majority held that "the State may not require separate licensure of facilities primarily devoted to performing abortions." The majority opinion is in conflict with decisions of this Court and other courts of appeals as to the authority of the State to license and regulate outpatient surgical facilities in which pregnancy terminations are performed. The State has the duty and authority to license and regulate such facilities in the same manner as facilities in which other outpatient surgical procedures are performed.

This Court has consistently held, even with respect to first trimester abortions, that the State has an interest in making sure that certain factual assumptions made in *Roe v. Wade*, 410 U.S. 113 (1973) continue to exist. As explained in *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 430 n.12 (1983):

> Of course, the State retains an interest in ensuring the validity of Roe's factual assumption that "the first trimester abortion [is] as safe for the woman as normal childbirth at term," an assumption that "holds true only if the abortion is performed by medically competent personnel under conditions insuring maximum safety for the woman." *Connecticut v. Menillo*, 423 U.S. 9, 11, 46 L.Ed.2d 152, 96 S.Ct. 170 (1975) (per curiam).

The ASTC Act seeks to effectuate that interest by "assuring that all medical procedures, including abortions, are performed under conditions that insure maximum safety." (App. 149).

Thus, two other courts of appeals have upheld licensing standards of outpatient surgical facilities in which pregnancy terminations are performed. *Baird v. Department of Public Health*, 599 F.2d 1098, 1102 (1st Cir. 1979) ("There is room under *Roe* for states to apply the same licensing standards to abortion facilities as they apply to like facilities performing medically analogous procedures."); *Hodgson v. Lawson*, 542 F.2d 1350, 1358 (8th Cir. 1976) ("A state can impose the same regulations on a clinic, specifically built to perform abortions during the first trimester, that are imposed on other clinics that perform surgical procedures requiring approximately the same degree of skill and care as the performance of first trimester abortions.").

In this case, the HFP Act and the ASTC Act, as enforced, are abortion-neutral and are applicable to all licensed ASTCs, irrespective of the types of surgical procedures performed. These statutes were clearly enacted to further the State's interests in regulating the ever increasing number of outpatient surgical facilities. The State has responsibilities to its citizens to insure that medical procedures performed at these facilities are performed under circumstances enhancing their safety. Further, the State can legitimately seek to establish a comprehensive and less costly health care delivery system. Those responsibilities do not cease when an abortion is the surgical procedure which is to be performed.

In addition, the majority rejected the argument that abortion-neutral regulations should be scrutinized under a different standard than abortion-specific regulations. Defendants maintain that such argument is clearly supported by the two previously cited opinions from the First and Eighth Circuit Courts of Appeals. *Accord, Westchester*

Women's Health Org. v. Whalen, 475 F.Supp. 734 (S.D. N.Y. 1979) (requirements governing "diagnostic and treatment centers" applicable to facilities performing first trimester abortions); *Abortion Coalition of Mich. Inc. v. Mich. Dep't of Public Health*, 426 F.Supp. 471 (E.D. Mich. 1977) (requirements for "free standing surgical outpatient facilities" applicable to facilities performing first trimester abortions).

The argument that abortion-neutral regulations should be scrutinized under a less exacting standard than abortion-specific regulations is also supported by decisions of this Court in other contexts. *City of Renton v. Playtime Theatres, Inc.*, 475 U.S. 41, 46-47 (1986) (standards under First Amendment for "content-based" and "content-neutral" zoning regulations); *Minneapolis Star & Tribune Co. v. Minn. Comm'n of Revenue*, 460 U.S. 575, 582-83 (1983) (standards under First Amendment for general and special taxes as applied to the press). *Accord, Arcara v. Cloud Books, Inc.*, 478 U.S. 697, 106 S.Ct. 3172, 3177 (1986) (First Amendment is not implicated by the enforcement of a public health regulation of general application against the physical premises in which sexually explicit books and magazines are sold). Thus, defendants maintain that the lower courts applied an erroneous legal standard to the abortion-neutral provisions.

Even if the strict scrutiny test was correctly determined to apply, the majority erred in determining that plaintiffs had established a sufficiently substantial interference with the abortion decision. The majority opinion misapprehended the testimony regarding the purported cost of compliance with the State regulations.[2] While the majority opinion states that Dr. Ragsdale's estimated compliance with the regulations would entail a per patient cost of between $25 and $40 (App. 22), the actual testimony was that reasonable compliance would only result in an estimated $25.21 per patient fee increase. That increase would be reduced to $10.90 after two years and $3.40 after five years due to the retirement of certain debts. This increase is *de minimis* and did not sustain plaintiffs' burden of proof even under the standards found applicable by the majority. (App. 23).

[2] The majority opinion also incorrectly found that Dr. Ragsdale was permitted to testify as to the substance of his handwritten

(Footnote continued on following page)

For example, in *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476 (1983), this Court considered the impact on the woman's exercise of her right to decide whether to have an abortion caused by the cost of a State required pathology report. This Court held that the estimated cost of $19.40 per patient did not "significantly burden a pregnant woman's abortion decision." *Id.* at 490.

Similarly, in the instant matter, plaintiffs' cost estimates did not establish a "sufficiently substantial" interference with a pregnancy termination decision. Thus, the lower courts erred in applying a strict scrutiny standard to the challenged provisions, and in determining that those provisions were invalid under that standard.

[2] *continued*
cost estimates, without objection. (App. 22). As correctly stated in the dissenting opinion, "the defendants objected throughout the hearing as to the relevancy and admissibility of Ragsdale's alleged cost sheets" (App. 67). At the outset, defendants objected to any use of those documents. Further objections were raised when plaintiffs moved for their admission into evidence.

C.

THE MAJORITY OPINION CONFLICTS WITH DECISIONS OF THIS COURT REGARDING SEVERANCE OF PURPORTEDLY UNCONSTITUTIONAL PROVISIONS.

Assuming, *arguendo*, that the lower courts appropriately assumed jurisdiction over the challenged provisions which are not being enforced, those courts should have severed any purportedly unconstitutional statutes or regulations. For instance, the abortion-specific language of par. 157-8.3 of the ASTC Act has not been enforced since 1981 due to the decision of the Illinois Supreme Court in *Village of Oak Lawn v. Marcowitz*, 86 Ill.2d 406 (1981). In that case, the court struck down a portion of a local ordinance that incorporated the ASTC Act definition of an ASTC. The disputed portion covered "any facility where a medical or surgical procedure is performed for the termination of pregnancy, regardless of whether the facility is primarily devoted to that purpose." *Id.* at 420. The court severed that portion, but found the remaining portion of the ordinance to be "complete in itself and susceptible to independent enforcement." *Id.* at 421.

In the instant appeal, the majority opinion rejected the argument that any purportedly unconstitutional provision be severed. It characterized the regulatory scheme as being "so riddled with exceptions resulting from judicial decisions and nonenforcement policies as to be unintelligible." (App. 33).

Defendants submit that a court should focus upon the provisions independently and on their own merit. Otherwise, litigants will be encouraged to base their litigation strategy upon the sheer number or volume of statutes and regulations to be attacked on constitutional grounds. The more broad based the attack, the greater the purported burden on constitutional guarantees.

As this Court has noted, a court should refrain from invalidating more of a statute than is necessary. *Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984). It is, moreover, the duty of the court to "maintain the act in so far as it is valid." *Id.* at 652, quoting *El Paso & Northeastern R. Co. v. Gutierrez*, 215 U.S. 87, 96 (1909). Likewise, this Court has held that "[u]nless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law." *Buckley v. Valeo*, 424 U.S. 1, 108-09 (1976), quoting *Champlin Refining Co. v. Corporation Commission*, 286 U.S. 210, 234 (1932).

Given the ASTC Act's declared purpose of assuring that *all* medical procedures, including abortion be performed under circumstances insuring maximum safety, the Supreme Court of Illinois' holding on severability in *Marcowitz*, and the State's policy of nonenforcement, there is no doubt that the abortion-specific language of the ASTC Act should have been severed if declared unconstitutional. Likewise, any purportedly unconstitutional provisions of the HFP Act and the ASTC regulations should have been severed. By failing to appropriately address the severability issue, the majority opinion has improperly frustrated the intent of the elected representatives of the people of the State of Illinois. *Regan v. Time, Inc.*, 468 U.S. at 653.

CONCLUSION

For these reasons, this Court should note probable jurisdiction of this appeal.

Respectfully submitted,

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November 10, 1988

APPENDIX

88-790

No.

Supreme Court, U.S.
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CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, et al.,

Appellants,

v.

RICHARD M. RAGSDALE, M.D., et al.,

Appellees.

On Appeal From The United States Court Of Appeals For The Seventh Circuit

APPENDIX TO JURISDICTIONAL STATEMENT

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INDEX TO APPENDIX

	PAGE
A—Slip Opinion of the United States Court of Appeals for the Seventh Circuit, March 10, 1988	1
B—Judgment of the United States Court of Appeals for the Seventh Circuit, March 10, 1988	102
C—Order of the United States Court of Appeals for the Seventh Circuit Amending the Slip Opinion, April 13, 1988	103
D—Amended Order of the United States Court of Appeals for the Seventh Circuit Denying the Petition for Rehearing and Suggestion for Rehearing *En Banc*, August 16, 1988	105
E—Order of the United States Court of Appeals for the Seventh Circuit Denying the Petition for Rehearing and Suggestion for Rehearing *En Banc*, August 12, 1988	107
F—Class Certification and Preliminary Injunction Order of the United States District Court for the Northern District of Illinois, Eastern Division, December 11, 1985	109
G—Memorandum Opinion and Order of the United States District Court for the Northern District of Illinois, Eastern Division, November 27, 1985	112
H—Notice of Appeal, November 7, 1988	146

I– Ambulatory Surgical Treatment Center Act, 111½ Ill. Rev. Stat. ¶¶ 157-8.1, *et seq.* 149

J– Health Facilities Planning Act, 111½ Ill. Rev. Stat. ¶¶ 1151, *et seq.* 166

K– Medical Practice Act, 111 Ill. Rev. Stat. ¶ 4400-22 193

L– 77 Illinois Administrative Code, Chapter 1, § 205, Subchapter b 203

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APPENDIX A

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 85-3242

RICHARD M. RAGSDALE, et al.,

Plaintiffs-Appellees,

v.

BERNARD J. TURNOCK, Director of the Illinois Department of Public Health, et al.,

Defendants-Appellants.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 85-C-6011—**John A. Nordberg,** *Judge.*

ARGUED OCTOBER 22, 1986—DECIDED MARCH 10, 1988

Before BAUER, *Chief Judge*, COFFEY, *Circuit Judge*, and ESCHBACH, *Senior Circuit Judge.*

ESCHBACH, *Senior Circuit Judge.* Plaintiffs consist of a class of all duly licensed physicians and surgeons performing or who desire to perform pregnancy terminations in Illinois and a class of all women in the State of Illinois of child-bearing age who desire or may desire an abortion at sometime in the future. Defendants are a class of the State's Attorneys of all of the counties of the State of Illinois,[1] the Director of the Illinois Department of Public

[1] Class certification as to both the defendant and plaintiff classes was challenged below. The district court granted certification. 625 F. Supp. at 1219-24. That ruling is not challenged on appeal.

Health, the Illinois Attorney General, and the Director of the Illinois Department of Registration and Education. Plaintiffs sued under 42 U.S.C. § 1983 and 28 U.S.C. §§ 2201-02, seeking declaratory and injunctive relief to the effect that three Illinois statutes and the regulations thereunder violate the constitutional right to privacy, specifically to abortion, as established in *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 705 (1973), and subsequent Supreme Court cases. This case comes to us on appeal from the district court's grant of plaintiffs' motion for a preliminary injunction. 625 F. Supp. 1212 (N.D. Ill. 1985). Because we believe certain of the claims are moot, we vacate in part. In most respects, however, we affirm the preliminary injunction.

I

A. Statutory and Regulatory Provisions

The statutory and regulatory scheme is somewhat complex. Therefore, we set it out in some detail. Section 16(1) of the Medical Practice Act ("the MPA"), 111 Ill. Rev. Stat. ¶ 4433(1), allows for revocation or suspension of the license of any physician who performs an "elective abortion" in any place other than a licensed Ambulatory Surgical Treatment Center ("ASTC"), a hospital, or a facility run by the state or federal governments.[2] The Ambulatory Surgical Treatment Center Act, 111½ Ill. Rev. Stat. ¶¶ 157-8.1, *et seq.* (the "ASTCA" or the "Act"), provides for the licensure of all ASTCs, which it defines as "any . . . place . . . devoted primarily to . . . the performance of surgical procedures or any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose. . . ." 111½ Ill. Rev. Stat. ¶ 157-8.3(A). In addition, plaintiffs have challenged those sections of the Health Facilities Providers Act, 111½ Ill. Rev. Stat. ¶¶ 1151, *et seq.* ("HFPA"), which require anyone seeking to open an ASTC to obtain a certificate of need for the facility from the Department of Public Health after a public hearing and 120-day review period. *See* 111½ Ill. Rev. Stat. ¶¶ 1155-1160.[3]

[2] Section 16(1) of the Medical Practice Act reads, in pertinent part:

> The Department may revoke, suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license . . . of any person . . . in this state to practice medicine . . . upon any of the following grounds:
>
> (1) Performance of an elective abortion in any place . . . other than:
>
> (a) a facility licensed pursuant to the "Ambulatory Surgical Treatment Center Act" . . .;

(Footnote continued on following page)

[2] *continued*

> (b) [a licensed hospital];
>
> (c) an ambulatory surgical treatment center or hospitalization or care facility maintained by the State or any agency thereof . . .;
>
> (d) ambulatory surgical treatment centers, hospitalization or care facilities maintained by the Federal Government, or
>
> (e) ambulatory surgical treatment centers, hospitalization or care facilities maintained by any university or college established under the laws of this State and supported principally by public funds raised by taxation. . . .

[3] Section 1158 of the Health Facilities Planning Act reads, in pertinent part:

> . . . When an application for a permit is initially reviewed by a recognized areawide health planning organization or [the Department of Public Health] . . . [they] shall afford an opportunity for a public hearing within a reasonable time after receipt of the complete application. . . . Such hearing shall be conducted in the area or community where the proposed project is to occur, and shall be for the purpose of allowing the applicant and any interested person to present public testimony concerning the approval, denial, renewal or revocation of the permit. . . . The State Board shall promulgate reasonable rules and regulations governing the procedure and conduct of such hearings.

The bulk of plaintiffs' specific challenges, however, are directed at the ASTCA and the regulations promulgated thereunder, and their application, via the MPA, to physicians desiring to perform first and early second trimester abortions. Accordingly, we set forth the ASTCA and its accompanying regulations in some detail.[4]

The Act itself is largely procedural in operation and grants the Department of Public Health the authority to promulgate specific regulations governing ASTCs. 111½ Ill. Rev. Stat. ¶ 157-8.10. However, certain specific provisions of the statute also prescribe requirements for ASTCs. Section 6.1 of the ASTCA requires any corporation operating an ASTC devoted primarily to providing facilities for abortion to have on its board of directors a physician who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the ASTC. Sections 157-8.5 and 8.6 generally provide for licensing with an initial fee of $500 and an annual renewal fee of $300. Additionally, those sections require that a licensed facility be under the supervision of one or more physicians and that at least one physician have admitting and surgical privileges at an Illinois hospital. Sections 157-8.7a and 8.7b require statements regarding the ownership of and financial condition of the facility. Section 157-8.8 requires Department approval of construction of, alterations of, or additions to a facility. Section 157-8.9 provides for quarterly inspections of facilities and provides for confidentiality of information received by the Department.

The remedial sections of the Act provide an array of enforcement mechanisms. Section 157-8.9a provides that a facility may be closed by administrative order if its continued operation constitutes an imminent and serious menace to the health or safety of the patients or if the operator thereof has been convicted of a violation of sec-

[4] Selected regulations that are discussed in detail in our analysis *infra* in the text are set forth in an Appendix to this opinion.

tion 157-8.12. Section 157-8.12 provides for a fine of $10,000 per day for operating a facility without a license or otherwise violating the Act. Section 157-8.13 makes the operation of a facility in violation of the Act or regulations a public nuisance subject to injunction.

Section 157-8.15 provides, in broad terms, for severability of the provisions of the Act.

The general regulations under the ASTCA, found in Title 77 of the Illinois Administrative Code, are detailed and govern many aspects of an ASTC.

For example, there are quite specific physical plant regulations which require: (1) a minimum size of 250 sq. ft. or at least one procedure room (any additional ones must be no smaller than 120 sq. ft.) and a minimum of 80 sq. ft. for examinations rooms; (2) that an ASTC be "identifiably separate from other medical facilities and functions"; (3) that a "control station" be located to allow visual surveillance of traffic entering the operating suite; (4) that facilities including a lounge, lockers, separate toilets, and a space for changing clothes be provided for male and female personnel; (5) a separate janitorial closet for the surgical suite; (6) a "diagnostic facility" if pre-admission evaluation tests are to be performed; and (7) minimum corridor (5′ or 8′ depending on whether stretchers are to be used) and door (3′ or 3′8″) widths. § 205.1310-1390. Also, an elaborate air-conditioning, heating, and ventilation system to provide for specific filter efficiencies and airflow relationships between rooms is required. § 205.1540 and Table A.

The licensure regulation provides for a detailed application including identification of the owners and operators of the facility, its location, a description and architectural plans, documentation of compliance with building and safety codes, a description of the services to be performed, and a list of all personnel and their qualifications. A new application is required for a change in ownership, location of the facility, remodeling, or addition of services or programs. Notice to the Department must be given of any

change in the administrative staff, medical director, staff physicians, supervising nurse, addition or deletion of surgical procedures, or change in any shareholder interest of five percent or more. § 205.120.

Other general requirements include an organizational plan which is available for public information, a policies and procedures manual, and written personnel policies including job descriptions. § 205.310. All facilities are required to have the following personnel present during the operative and post-operative period for all patients: a physician, a registered professional nurse with post-graduate education or experience in surgical nursing, and a person certified in "Basic Life Support" by the American Heart Association. Sections 205.320-40. Additionally, each facility must have either a certified medical technician or a written agreement with a licensed laboratory to perform required laboratory procedures. § 205.350. A consulting committee must be established to develop standards of professional work and a physician must serve as the medical director of the facility. § 250.230.

With regard to equipment, all facilities are required to have monitoring equipment, suction apparatus, oxygen, and cardiac pulmonary resuscitation equipment. § 205.410. Additional written procedures are required to govern care, use, sterilization, storage and disposal of all materials, and to govern storage and use of all medications. *Id.* Additional written procedures are required for garbage and refuse removal, insect and rodent control, and maintenance of heating, ventilation and utility service. § 205.420.

Patient care regulations include a requirement of a written "emergency" procedure in case of fire, explosion, or "other non-patient medical emergency," and preparation to manage the emergencies normally associated with the surgical procedures performed. § 205.510. A "complete physical" is required and specified tests are required to be performed by a qualified laboratory technician for any procedures performed under general anesthesia, local anesthesia with sedation, or any pregnancy termination. A signed, written informed consent for any procedure is to

be maintained with the patient's clinical records. § 205.520. All removed tissues are to be examined by a consulting pathologist. § 205.530.

Post-operative care regulations provide that any patient who has had general anesthesia, local anesthesia with sedation, or pregnancy termination is required to be observed for a period of time sufficient to detect any immediate post-operative complications, and that no patient be required to leave in less than one hour. § 205.540. Additionally, written documentation is required of a transfer agreement with a licensed hospital within fifteen minutes of the facility, or that the medical director of the ASTC (or each staff physician of the ASTC) has admitting privileges at such a hospital. § 205.540.

Detailed clinical records are also required to be maintained. § 205.610. Additionally, facilities are required to make annual statistical reports that include the number and type of procedures performed, the number and type of complications reported, the number of patients requiring transfer to a hospital due to complications, the number of patients returning for follow-up, and the number of deaths.

The regulations also have an abortion-specific subpart which requires: (1) at least one registered professional nurse with post-graduate education or experience in obstetrical or gynecological nursing, section 205.720; (2) testing and reporting of the results to the patient of blood Rh factor and diagnosis of pregnancy, section 205.730(a); and (3) counseling by someone specifically trained to give it and who has no financial interest in the patient's decision, which counseling must include a discussion of alternatives, description of the procedure to be performed, and an explanation of risks and possible complications, section 205.730(b). Contraceptive information may be provided post-operatively, and shall be provided if desired by the patient. *Id.* Counseling must take place in a room separate from the procedure room, and a record of the counseling given is to be included in the patient's clinical record. *Id.*

The subpart contains its own reporting requirement which requires monthly reporting of each procedure "on forms provided by [the Department]." Additionally, the regulations prohibit an ASTC from performing abortions on patients with a gestational age exceeding twelve weeks. § 205.740.

B. Enforcement Policies

Not all of the provisions of challenged statutes and regulations are being enforced. Since 1981, the Act and regulations have been applied only to facilities which are primarily devoted to the performance of surgical procedures (including abortions). This enforcement policy was adopted in response to *Village of Oak Lawn v. Marcowitz*, 86 Ill. 2d 406, 427 N.E.2d 36 (1981), which refused to enforce, in a criminal proceeding, that portion of a local ordinance which incorporated the ASTCA definition of an ASTC which covered "any facility where a medical or surgical procedure is performed for the termination of pregnancy, regardless of whether the facility is primarily devoted to that purpose." The defendants also contend that the MPA's revocation or suspension sanction for performing abortions outside an ASTC is similarly not being enforced, but the evidence on this point is equivocal.

The defendants also contend that the prohibition on performance of second trimester abortions in ASTCs is not being enforced because it was considered enjoined by the order in *Paula Poe v. IDPH*, No. 78-C-4126 (N.D. Ill. 1982). In that case, enforcement of section 4 of the Illinois Abortion Law of 1975, 38 Ill. Rev. Stat. § 81-24, which required all second trimester abortions to be performed in a hospital, along with "any related regulation" was enjoined pending decision of three Supreme Court cases involving a second trimester hospitalization requirement. *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 103 S. Ct. 2481 (1983); *Planned Parenthood Association, Inc. v. Ashcroft*, 462 U.S. 476, 103 S. Ct. 2517 (1983); and *Simopoulos v. Virginia*, 462 U.S. 506, 103 S. Ct. 2532 (1983). An internal memorandum of the Department of Public Health following the decisions in those cases opined that they confirmed the unconstitutionality of the second trimester hospitalization requirement in the Illinois statutes and regulations. *See* Deft. Ex. 4. Representatives of the defendants testified at trial that the requirement is not currently being enforced for this reason.

Defendants also contend that section 10 of the Illinois Abortion Law of 1975, an abortion-specific reporting requirement, was enjoined by Judge Kocoras in *Charles v. Carey*, 579 F. Supp. 464 (N.D. Ill. 1983), *aff'd in part, rev'd in part on other grounds Charles v. Daley*, 749 F.2d 452 (7th Cir. 1984) (*Charles II*), *appeal dismissed sub nom. Diamond v. Charles*, 106 S. Ct. 1697 (1986), and that the abortion-specific reporting requirement in the ASTC regulations has not been enforced since that time.

These non-enforcement policies are not publicly stated, but persons who inquire of the various enforcement agencies are informed of them.

C. Individual Plaintiff Dr. Ragsdale

The individual plaintiff physician was required to relocate his practice, the Northern Illinois Women's Center ("the NIWC"), which is the only facility of its kind (that is, a non-hospital clinic) offering abortion services in a large area of northwestern Illinois because his landlord refused to renew his lease. The facility which he had been operating was not in full compliance with the ASTCA regulations, but was nonetheless licensed as "substantially complying" with them. When he sought another location, he had to go through the certificate-of-need proceedings. The required public hearing on the application degenerated into a shouting match between "pro-choice" and "pro-life" members of the public, after which the doctor's prospective landlord withdrew his lease commitment. In addition, officials charged with enforcing the regulations told him that they would require "considerably more substantial compliance" than had been the case with his prior facili-

ty, particularly with respect to the architectural requirements. The cost of either building a facility or renovating one to comply with the regulations was estimated by the plaintiff at between $25.21 and $47.66 per patient. Because of his inability to find a location that can be renovated to comply with the ASTCA, particularly the structural and physical plant requirements of the regulations, at a reasonable cost, Dr. Ragsdale will close the NIWC unless the statute is enjoined.

D. Individual Plaintiff Margaret Moe

Margaret Moe is a registered nurse who currently operates two medical facilities in the State of Illinois. The facilities offer family planning education and medical care that includes the prescription of contraceptives, prenatal care, and delivery assistance for pregnant women. Her clinics receive approximately sixty requests for abortions each week. She would like to offer abortion services at her clinics, and she has on staff physicians who are competently trained and willing to perform such abortions. However, her facilities do not comply with the structural requirements of the Act and regulations and cannot be renovated to so comply without prohibitive cost. Accordingly, she does not offer such services.

II

We first consider whether certain of plaintiffs' challenges have been mooted by the State's non-publicized policy of non-enforcement.[8] It is well established that voluntary cessation of putatively illegal conduct ordinarily will not

[8] We note that the defendants did not argue that portions of the case were moot until their reply brief, arguing in their initial brief only that the non-enforcement policy meant that the plaintiffs were not being irreparably harmed by the statutory scheme. Nonetheless, as we are under a duty to determine our own jurisdiction, we must consider the question of mootness even if no party properly raises it.

moot a controversy and prevent its adjudication by a federal court. *City of Mesquite v. Aladdin's Castle, Inc.*, 455 U.S. 283, 289 & n.10, 102 S. Ct. 1070, 1074 & n.10 (1982); *County of Los Angeles v. Davis*, 440 U.S. 625, 631, 99 S. Ct. 1379, 1383 (1979); *United States v. W.T. Grant Co.*, 345 U.S. 629, 632-33, 73 S. Ct. 894, 897 (1953); *see also Charles v. Daley*, 749 F.2d 452, 456-58 (7th Cir. 1984) (*Charles II*), *appeal dismissed sub nom., Diamond v. Charles*, 106 S. Ct. 1697 (1986). However, such cessation does render a controversy moot where there is no reasonable expectation that the putatively illegal conduct will be repeated, and there are no remaining effects of the alleged violation. *Davis*, 440 U.S. at 631, 99 S. Ct. at 1383; *W.T. Grant*, 345 U.S. at 633, 73 S. Ct. at 897. Defendants bear a heavy burden of persuading the court that a controversy is moot. *United States v. Phosphate Export Association, Inc.*, 393 U.S. 199, 203, 89 S. Ct. 361, 364 (1968); *W.T. Grant*, 345 U.S. at 633, 73 S. Ct. at 897; *Charles II*, 749 F.2d at 457; *Sanchez v. Edgar*, 710 F.2d 1292, 1294-95 (7th Cir. 1983).

We note additionally that cessation of the allegedly illegal conduct by government officials has been treated with more solicitude by the courts than similar action by private parties. According to one commentator, such self-correction provides a secure foundation for a dismissal based on mootness so long as it appears genuine. *See* 13A Wright, Miller & Kane *Federal Practice and Procedure* § 3533.7, at 353 (2d ed. 1984).

A.

We believe that application of these general principles to the present circumstances mandates a conclusion that plaintiffs' challenge to the second trimester hospitalization requirement is moot. As we have noted above, the defendants have conceded, at least since 1983, that this requirement is unconstitutional under governing Supreme Court decisions and is therefore not enforced. Plaintiffs have not attempted to counter the defendants' showing

on this point, nor do we believe they could. The individual plaintiff Dr. Ragsdale testified that he was informed by a State inspector that the hospitalization requirement was not being enforced and that after that time he began performing early second trimester abortions at his facility.

Analogous assurances of discontinuance of the challenged conduct have been held to render challenges moot in other cases. For example, in *McRary v. Polythress*, 638 F.2d 1308 (5th Cir.), *cert. denied*, 454 U.S. 865, 102 S. Ct. 325 (1981), election officials conceded that they had erred by attempting to compel a political candidate to file certain financial disclosure reports and wrote the candidate abandoning their request for such reports. This, according to the court, mooted the challenge to the officials' action because "Appellant 'has presented no evidence creating a reasonable expectation that the [Commission] will repeat its purportedly unauthorized actions in subsequent elections. Appellant's conclusory assertions that the actions are capable of repetition are not sufficient. . . . .'" *Id.* at 1310 & n.1 (quoting *Illinois State Board of Elections v. Socialist Workers Party*, 440 U.S. 173, 187, 99 S. Ct. 983, 992 (1979). In *Northern Virginia Women's Medical Center v. Balch*, 617 F.2d 1045 (4th Cir. 1980), an even more questionable assurance of discontinuance was held to moot the controversy. There, a local prosecuting attorney's policy of not enforcing a state trespass statute against anti-abortion protestors who unlawfully entered and blocked access to an abortion clinic was challenged as a denial of Equal Protection. The court held that the prosecutor's assertion at oral argument that the non-enforcement policy had been abandoned, coupled with the fact that prosecutions had in fact occurred during the pendency of the litigation, rendered the challenge moot. According to the court, "[s]ince the good faith of this representation is not questioned, we conclude that the controversy between the Center and the commonwealth attorney is now moot and that it is not likely to be revived." *Id.* at 1049.

We believe that the defendants' now public policy of non-enforcement of the hospitalization requirement, particularly in view of the reasons therefor (*i.e.*, that enforcement is barred by clear Supreme Court precedent), moots any challenge to that requirement. While we share plaintiffs' concern that the State has not acted to remove or amend the statute and regulations, we know of no authority by which we can require it to do so. The most we could do, and all plaintiffs request of us, is to enjoin their enforcement. Federal courts do not, as a rule, enjoin conduct which has been discontinued with no real prospect that it will be repeated. Accordingly, the challenge to the second trimester hospitalization requirement should have been dismissed. Therefore we vacate the portion of the injunction that pertains to it.

B.

However, we do not believe that the challenge to the reporting requirement of the ASTCA and regulations is moot. Although defendants testified that this requirement is no longer being enforced in light of *Charles v. Carey*, 579 F. Supp. 464 (N.D. Ill. 1983), we have reviewed that decision and cannot find anything in it which remotely supports the conclusion that the requirement under challenge here was enjoined. The only reporting requirement addressed by that decision was section 11(d) of the Illinois Abortion Act, which required the reporting to the Department of the name of any patient diagnosed as having complications from abortion. The more general requirements here are quite different. Unlike its representations of non-enforcement of the other sections, the State produced no pre-existing documentation of the policy. We share the district court's concern that the State's position on this provision is asserted only in this litigation.

C.

The challenge to the application of the ASTCA and regulations to first trimester abortions is similarly not moot.

While the requirement is apparently no longer applied to the "occasional" abortion provider, the State continues to maintain that it is free to apply the ASTCA to abortion providers whose practice is "primarily devoted to" performing surgery, even if that "surgery" consists exclusively of first trimester abortions. This is in fact the situation facing at least one of the named plaintiffs, Dr. Ragsdale.

Additionally, the evidence regarding the suspension/ revocation sanction in the MPA was, as we have noted, ambiguous. A representative of the Department merely testified that any complaint regarding this provision would be "examined by the General Counsel's office for a determination of whether there would be any enforcement action taken pursuant to that section." He additionally testified that "to the best of [his] knowledge" the Department would not enforce the section. While we admit that it would be anomalous for the Department to take the position that "occasional" abortion providers need not be licensed but that performance of such abortions could subject the physicians to revocation of their licenses to practice medicine, the Department's position is sufficiently murky and the sanctions sufficiently severe, that we believe a live controvery exists regarding this requirement. Doctors should not have to risk loss of their professional licenses to explore the contours of the asserted non-enforcement position.

III

On the merits,[6] we must consider whether the requirements of the statutory and regulatory scheme violate the

[6] On appeal, various of the defendants and amici contend that the district court did not properly weigh various of the factors which are normally considered in issuing a preliminary injunction. We note that the presentation of the case below focused almost exclusively on the constitutionality *vel non* of the statutory scheme or its component parts. None of the parties argued the traditional factors governing the granting of preliminary relief to the district

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right to privacy (and to abortion) as established in *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 710 (1973), and its progeny. In *Roe*, the Court first set out the now familiar "trimester" approach:

> (a) For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.
>
> (b) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.
>
> (c) For the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.

410 U.S. at 164-65, 93 S. Ct. at 732.

In elaborating on this approach, the Court noted that the State's interest in the health of the mother becomes compelling:

[6] *continued*
court. Although no doubt its task was made more difficult by the lack of assistance from the parties, the district court undertook a thorough examination of those traditional factors, *i.e.*, the lack of an adequate remedy at law, irreparable harm, balance of harms, likelihood of success on the merits, and the public interest. We confine our discussion to the likelihood of success on the merits, that is, the governing legal standards and their relationship to the facts found below for two related reasons. First, the balancing of the other factors is typically reviewed on an "abuse of discretion standard" and we see no abuse, and second, we find insufficient merit to any of the defendants' or the amicus' belated assertions that this or that factor was given insufficient weight to add to this already lengthy opinion.

in the light of present medical knowledge, . . . at approximately the end of the first trimester. This is so because of the now-established medical fact, . . . that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth. It follows that, from and after this point, a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like.

This means, on the other hand, that, for the period of pregnancy prior to this "compelling" point, the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated. If that decision is reached, the judgment may be effectuated by an abortion free of interference by the State.

Id. at 163, 93 S. Ct. at 731-32.

Since *Roe*, the Court, along with the lower federal courts, has on numerous occasions clarified the constitutional standards which apply to regulations aimed at both first and second trimester abortions. Few restrictions on first trimester abortions have been upheld. For example, the Court upheld a requirement that all abortions be performed by a licensed physician. *Connecticut v. Menillo*, 423 U.S. 9, 96 S. Ct. 170 (1975) (*per curiam*). This requirement, apart from being endorsed in *dictum* in *Roe*, was upheld because "the State retains an interest in ensuring the validity of Roe's factual assumption that 'the first trimester abortion [is] as safe for a woman as normal childbirth at term,' an assumption that 'holds true only

if the abortion is performed by medically competent personnel under conditions insuring the maximum safety of the woman.' " *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 430 n.12, 103 S. Ct. 2481, 2492 n.12 (quoting *Menillo*, 423 U.S. at 11, 96 S. Ct. at 171).

Likewise, the Court upheld a state-required pathology examination which required tissues removed by abortion, like all other removed tissues, to be examined by a pathologist. *Planned Parenthood Association, Inc. v. Ashcroft*, 462 U.S. 476, 103 S. Ct. 2517 (1983). This was because such an examination was considered "absolutely necessary" from a medical standpoint and " 'abnormalities in the tissue may warn of serious, possibly fatal disorders.' " *Id.* at 487-89, 103 S. Ct. at 2523-24. According to the Court, certain regulations of even first trimester abortions that " 'have no significant impact on the woman's exercise of her right [to have an abortion] may be permissible where justified by important state health objectives.' " *Id.* at 489-90, 103 S. Ct. at 2524 (quoting *Akron*, 462 U.S. at 430, 103 S. Ct. at 2492-93 (alterations by the Court)).

The quoted language clearly indicates that, where first trimester abortions are involved, not only must the impact of the challenged regulation be insignificant in terms of the woman's exercise of her right, but also that the regulation must be "justified by important state health objectives." This is consistent with our own case law to the effect that once such regulations are shown to have more than a *de minimus* impact on the abortion decision, the government must show a compelling basis for the law, *i.e.*, that the burden is not undue or unjustifiable. *Charles v. Carey*, 627 F.2d 772, 777 (7th Cir. 1980) (*Charles I*), *on remand*, 579 F. Supp. 464 (N.D. Ill. 1983).[7]

[7] Appellants make much of the fact that the district court connected the two parts of the *Charles I dictum* with "and" rather than "that is," claiming that the district court thus applied an improper standard. *See* 625 F.2d at 1230. This claim is meritless.

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Appellants contend that the district court's application of a "medical necessity" standard was error. We disagree. First, we believe that a "medical necessity" standard, at least as the term was used in the testimony below, is entirely consonant with the standards to be applied to regulations regarding first trimester abortions. *See Akron*, 462 U.S. at 430, 103 S. Ct. at 2492-93 (such restrictions must be "justified by important state health objectives"); *Ashcroft*, 462 U.S. at 487, 103 S. Ct. at 2523 (pathology examination requirement upheld because "absolutely necessary" from a medical standpoint). Additionally, it is clear from a review of the transcript that when the experts below testified that a requirement was not "medically necessary," they meant by that term that it had no real relationship to safety or health. *See, e.g.*, R. Vol. I at 112 (testimony of Dr. Ragsdale) (certain provisions not medically necessary because without "any real relationship to the particular circumstances" of physician performing abortions). According to the testimony, the minimum size requirements for examination rooms, procedure rooms, recovery rooms, corridors and doors, for example, not only were not "medically necessary," but do not enhance the safety of the abortion procedure "in any way" or did not have "any medical justification." R. Vol. I at 263-72 (testimony of Dr. Hern); *see also* R. Vol. I at 154 (testimony of Dr. Ragsdale) (large procedure room "not only medically unnecessary but medically poor"). The district court found, with full support from the record, that the physical plant requirements of the regulations required ASTCs to

[7] *continued*
Charles I in fact reiterated the standard enunciated by the Supreme Court, that the state must justify its regulation with a compelling interest and show that the regulation is narrowly drawn to express only that interest. *See* 627 F.2d at 776-78. Scrutiny of such laws always involves two questions: (1) how important the asserted state interest is, and (2) how well the regulation is drawn to achieve only that interest. *Charles I* did not intend to suggest that the second inquiry was unnecessary, and appellants' reliance on it for that purpose is misplaced.

be "the functional equivalent of small hospitals," 625 F. Supp. at 1216, and that these requirements "may be medically detrimental." *Id.* at 1230 n.23.

We note as well that the question whether some or all of the requirements of the statute and regulations could be constitutionally applied to early second trimester abortions is a more nettlesome one, but it is a question which we need not decide.[8] The statute and regulations do not

[8] A number of the regulations involved may well pass muster under the less stringent standard of review applied to state regulation of second trimester abortions. That standard allows the state to regulate second trimester abortions to the extent that the regulation "reasonably relates to the preservation and protection of maternal health," but it may not "adopt abortion regulations that depart from accepted medical practice." *Akron*, 462 U.S. at 430-31, 103 S. Ct. at 2493. The experts who testified at hearing described many of the requirements as "consistent with accepted medical practice." While it is true, as the district court found, that "[t]his is not equivalent to a showing of medical necessity," such a showing is not required for regulations which apply only to the second trimester.

We note that the Supreme Court stated in *Roe* that the state's interest in maternal health during the second trimester extends to "the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic of some other place of less-than-hospital status; as to the licensing facility; and the like." 410 U.S. at 163, 93 S. Ct. at 732. Further, in *Simopoulos v. Virginia*, 462 U.S. 506, 103 S. Ct. 2532 (1983), the Court rejected an attack on a criminal conviction, upholding against a charge of facial invalidity a statute requiring all second trimester abortions to be performed in a "hospital," where that term was defined to include facilities which were not full-fledged acute care hospitals. Thus, it appears that at least some licensing of facilities performing second trimester abortions would be permissible. However, we caution that the Court in *Simopoulos* specifically noted that "[w]e need not consider whether Virginia's regulations are constitutional in every particular. . . . [A]ppellant has not attacked them as being insufficiently related to the State's interest in protecting health." *Id.* at 513, 103 S. Ct. at 2539. Also, *Simopoulos*, unlike the present case, involved a late second trimester abortion performed using the saline instillation method.

(Footnote continued on following page)

distinguish between the two. Indeed, as written, due to the (now unenforced) second trimester hospitalization requirement, they originally applied *only* to first trimester abortions. Accordingly, as we have in other cases, we apply the legal standards applicable to restrictions on first trimester abortions. *See Charles I*, 627 F.2d at 782; *Friendship Medical Center, Ltd. v. Chicago Board of Health*, 505 F.2d 1141, 1149 (7th Cir. 1974), *cert. denied*, 420 U.S. 955, 95 S. Ct. 1438 (1975). We are simply not at liberty to insert the words "except with regard to first trimester abortions" into either the statute or the regulations. To do so would result in a scheme with little resemblance to that enacted by the Illinois legislature or the Department of Public Health. *See Thornburgh v.*

[8] *continued*

Much of the testimony below was to the effect that the requirements of the regulations bore little relationship to safe performance of early second trimester abortions as well as first trimester abortions. This should come as little surprise, since the medical procedures utilized are quite similar if not identical. We remind the State of the Supreme Court's admonition in *Akron* that:

> [I]f it appears that during a substantial portion of the second trimester the State's regulation "depart[s] from accepted medical practice," supra, at 2493, the regulation may not be upheld simply because it may be reasonable for the remaining portion of the trimester. Rather, the State is obligated to make a reasonable effort to limit the effect of its regulations to the period in the trimester during which its health interest will be furthered.

462 U.S. at 434, 103 S. Ct. at 2495.

Thus, while the trimester approach remains the applicable legal framework for weighing the competing interests involved in the abortion decision, it does not necessarily follow that all state regulations of abortion which are keyed to it are reasonable. Instead, the state should endeavor to draw its regulations designed to further maternal health in medically relevant terms (for example, certain of the requirements of the statute involved here may well make sense for late second trimester abortions which are performed under a general anesthetic, but not for simple "dilation and evaculation" abortions performed early in the second trimester).

American College of Obstetricians, 106 S. Ct. 2169, 2181 (1986).

Defendants suggest that, because the regulations apply to all facilities primarily devoted to surgery, we must review them under a different standard than if they had singled out abortions. We disagree. Defendants have cited us to no cases, and we have found none, which would justify such a distinction. In fact, *Friendship* suggests, albeit in *dictum*, exactly the opposite. 505 F.2d at 1153-54; *see also Birth Control Centers, Inc. v. Reizen*, 743 F.2d 352, 361-62 (6th Cir. 1984) (applying strict scrutiny notwithstanding general applicability of regulations).

We adhere to the statement in *Friendship* for several reasons. First, we cannot ignore the fact that the ASTCA was enacted primarily with abortion clinics in mind and only applied to outpatient surgical clinics generally in an effort to save the statute from unconstitutionality. *See* Pf. Ex. 22-24 (minutes of ASTC Licensing Board meetings). Secondly, the State cannot, merely by applying the expedient and conclusory label "surgery" to a medical procedure, apply requirements which would be necessary to major surgical procedures in the abortion context where they would be wholly inappropriate. It is as much a vice to treat abortion similarly to dissimilar procedures as it is to treat it differently from analogous procedures. In either case, imposition of burdensome requirements which are completely unnecessary to the performance of safe abortions is attempted. A prime example of this problem is the fact that many of the physical plant requirements of the regulations are designed with procedures to be performed under general anesthesia in mind, although the testimony in this case clearly established that first and early second trimester abortions of the type at issue here are not usually performed using such anesthesia and that, in fact, the use of a general anesthetic increases the risk of death and major complications from such procedures.

With the standards enunciated above in mind, we now turn to evaluation of the constitutionality of the challenged statutes and regulations.

IV

A.

The State initially contends that the plaintiffs have not met their threshold burden of showing an impact on the abortion decision. We must reject this contention. The district court found that the regulations at issue do substantially burden the effectuation of the decision to have an abortion. Specifically, the lower court found that the regulations raised the cost of abortions, by $25-$40 for abortions performed at Dr. Ragsdale's clinic, and, more importantly, that they would limit the availability of abortions in that, unless the regulations were enjoined, the clinic would close for lack of a suitable location that could be renovated to comply with them.[9] Additionally, the district court found that the regulations prevented individual plaintiff Moe from offering abortion services at her clinic because the cost of compliance was prohibitive. We cannot say these findings are clearly erroneous.

Dr. Ragsdale testified that he estimated compliance with the regulations would entail a per-patient cost of between $25 and $40.[10] While the defendants point out, correctly,

[9] The Americans United for Life Legal Defense Fund, as amicus curiae, contends that, because individual plaintiff Dr. Ragsdale would have had to relocate his clinic regardless of the regulations (due to an ostensibly unrelated business decision of his landlord), plaintiffs have presented no direct injury flowing from the challenged government conduct. However, this argument misses the critical point that the regulations make difficult, if not impossible, the relocation of an existing abortion practice or the commencement of a new one. As such, we have little doubt that plaintiffs have established a sufficient injury both to satisfy Article III and to warrant the grant of injunctive relief.

[10] Defendants place considerable emphasis on the allegedly erroneous admission of Dr. Ragsdale's handwritten cost estimates. We need not decide whether these constituted inadmissible hearsay, however, because Dr. Ragsdale testified at length, and without objection, to the substance of the estimates. Therefore, the admission of the written estimates themselves, if error, was surely harmless.

that this is not a great deal more than the cost of the pathology examination upheld in *Ashcroft*, they seem to have missed the import of that case. The Court did not hold that the impact was so small that the state was not required to justify it at all. It merely held that, during even the first trimester, requirements having an insignificant impact on the abortion decision were constitutional "where justified by important State health objectives." Thus, the regulations at issue here, which have a *greater* financial impact than that in *Ashcroft*, must be justified by at least similar state interests.

Additionally, although the financial per-patient cost of compliance might not seem overwhelming, it is not the only burden which must be considered. The lack of availability of abortions caused by the up-front cost and difficulty of obtaining a complying facility is at least as real and possibly more burdensome to women seeking abortions. Furthermore, there was testimony of the psychological burdens which would result from having to undergo an abortion in a hospital-like facility when the more psychologically comforting setting of a doctor's office would serve just as well from a medical standpoint. We cannot say that these burdens are "*de minimus*." *Cf. Charles I*, 627 F.2d at 777 ("direct interference" is shown where impact is not *de minimus* or where regulation imposes restrictions "that did not already exist"). Therefore, they must be justified by important state health objectives.

B.

The first facet of the scheme we consider is the requirement that facilities performing first trimester abortions be licensed at all. While this may not seem a particularly onerous requirement, we note Supreme Court precedent suggests only that a licensing requirement may be permissible in the second trimester. The Court stated in *Roe* that the state's interest in maternal health during the second trimester extends to "the facility in which the procedure is to be performed, that is, whether it must be

a hospital or may be a clinic of some other place of less-than-hospital status; as to the licensing of the facility; and the like." 410 U.S. at 163, 93 S. Ct. at 732. By contrast, the Court stated that during the first trimester "the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated. If that decision is reached, the judgment may be effectutated by an abortion *free from interference by the State*." *Id.* (emphasis added).

While we realize that the last quoted statement has been qualified by the Court in subsequent decisions (that is, where the "interference" does not have a significant impact and furthers important state health concerns), we nonetheless believe it retains force here. Thus, we are persuaded in this case that the State may not require separate licensure of facilities primarily devoted to performing abortions.

A primary factor which persuades us is that the State has in no way shown that performance of first trimester abortions in physicians' offices rather than heavily regulated ASTCs in any way undermines the safety of the operation. We further note that *Akron* itself seems to reject such an argument. 462 U.S. at 429 n.11. The State in fact basically concedes that it cannot prevent doctors from performing at least some abortions in their offices.

To the extent that there is any basis for distinguishing between a doctor who occasionally performs an abortion in his office and one whose practice is primarily devoted to such procedures, the regulations appear to run contrary to sound health policy. All of the expert testimony in the record is in agreement that the physician who performs many abortions in general will have more expertise and therefore a better safety record. The State's attempt to regulate experienced, and therefore safer, physicians, more heavily than the occasional abortion provider thus appears, as the district court noted, to lack even a reasonable basis.

We realize that the Sixth Circuit upheld a similar general licensing requirement in *Reizen*. However, in doing so, the court did not address a challenge based on the constitutional right to abortion, but rather an Equal Protection challenge based upon the physician's right to practice. Accordingly, the court applied a highly deferential "rational basis" standard of review. 743 F.2d at 358-59. As we have already held, such a standard of review is not appropriate in this case. Additionally, none of the evidence of the type mentioned above was apparently present in *Reizen*. There, the district court found that a private physician was more likely to have direct control over staff and procedures, but that the absence of this control might characterize a "clinic." Such findings are absent in this case.

Purely as a matter of the plain language of the statutory and regulatory scheme, once the licensing requirement falls, the remainder of the requirements fall with it (or, more properly, are inapplicable). The specific substantive requirements are not (leaving aside the unenforced requirement that all abortions must be performed in an ASTC) applicable to abortions, *per se*, but rather to ASTCs. In the alternative, however, we analyze those specific substantive aspects of the regulations focused on at trial which render the scheme unconstitutional as a whole.[11]

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[11] We do not decide whether particular provisions of the regulations not specifically mentioned in the text would, standing alone, pass constitutional muster. In particular, the pathology examination required by the general regulations seems nearly identical to that upheld in *Ashcroft*. Also the reporting requirement does not appear particularly onerous, nor does it appear calculated to raise the fear of harassment by physicians and patients by raising the spectre of public disclosure. Section 205.760 of the regulations merely requires a report of each procedure performed in an ASTC within ten days, and that such reports be made in such a manner and at such time so as not to avoid accurate reporting of complications. If complications become known to the ASTC, it is required to submit a supplemental report. Section 205.620, a non-abortion-specific reporting requirement, merely requires reporting

(Footnote continued on following page)

C.

The abortion-specific subpart of the regulations is of particular concern. Many of the requirements set forth in that subpart seem clearly contrary to either prior Supreme

[11] *continued*
of the number and type of procedures performed, the number and type of complications reported, the number of patients requiring transfer to hospitals, the number of patients returning for follow-up, and the number of deaths. These requirements appear to be consistent with *Planned Parenthood Association, Inc. v. Danforth*, 428 U.S. 52, 79-81, 96 S. Ct. 2831, 2846-47 (1976). The requirements are considerably less stringent than those previously enjoined. In particular, the name of the patient is in no way required to be disclosed to the State.

Additionally, a number of the other general requirements seem as though they would place no real burden at all on the abortion right. Requirements which may fall in this category might include the general provisions relating to personnel and administrative procedures governing ASTCs, such as those calling for a written policies and procedures manual, consulting committee, organization plan, personnel policies, and maintenance of a sanitary facility. Similarly, the operative care and post-operative care regulations may be in accord with accepted medical practice. Dr. Ragsdale objected to many of these requirements as "stating the obvious." However, so far as we are aware, there is no constitutional bar to "stating the obvious" even where abortion procedures are concerned.

Fewer of the abortion-specific regulations, as is evident from our discussion in the text, fall in this category. However, there was testimony below that the counselor qualification requirements of section 205.730(b)(2) were consistent with accepted medical practice. Additionally, subsection (1) of the same regulation merely requires, in general terms, that some counseling be given prior to the performance of an abortion (and that it occur in a room separate from the procedure room). As noted in the text *infra*, other aspects of the counseling requirements suffer from constitutional defects. Also, section 205.710 merely provides that "Abortions shall be provided to the public with the same standards of safety effectiveness, and regard for patients rights as any other health service."

Of course, we need not and do not decide the ultimate constitutionality of any of the requirements mentioned above.

Court precedent or our own cases. In particular, we note that section 205.730(a)(2) apparently requires the physician who is to perform the abortion to also perform a pregnancy test on the patient regardless of whether such testing had previously been done by another physician. We previously invalidated a similar "same doctor" requirement in an Illinois statute. *See Charles I*, 627 F.2d at 784, 786. The requirement in the instant regulation is, if anything, more burdensome and less justified than the one we invalidated there, which required only that the performing physician provide the patient with "a true copy" of her pregnancy test, rather than to possibly conduct a second test. For the same reasons as in *Charles I*, the provision in this case is invalid.

The counseling requirements too suffer from constitutional defects. Section 205.730(b)(3) attempts to prescribe the precise content of such counseling in mandatory terms applicable to all cases. The regulation states that counseling "shall include a discussion of alternatives, description of the procedure to be performed, explanation of the risks and possible complications." We believe that this provision, particularly the requirement of a "discussion of alternatives" is unconstitutional under the Supreme Court's recent decision in *Thornburgh v. American College of Obstetricians*, 106 S. Ct. 2169 (1986). The requirement "that a specific body of information be given in all cases, irrespective of the particular needs of the patient, intrudes upon the discretion of the pregnant woman's physician and thereby imposes the 'undesired and uncomfortable straitjacket' " which the Court has rejected. *Id.* at 2179 (quoting *Planned Parenthood Association, Inc. v. Danforth*, 428 U.S. 52, 67 n.8, 96 S. Ct. 2831, 2840 n.8). The informational requirements of the regulation are certainly not as intrusive or as specific as those previously stricken by the Court, but they are just as inflexible. Dr. Ragsdale testified below that some of the information, particularly the "discussion of alternatives" might not be appropriate for some patients. We agree that "for a patient with a life-threatening pregnancy, the 'information' in its

very rendition may be cruel as well as destructive of the physician-patient relationship." *Thornburgh*, 106 S. Ct. at 2180. We bear in mind that, during the second trimester at least, "the validity of an informed consent requirement . . . rests on the State's interest in protecting the health of the pregnant woman." *Id.* at 2179 (quoting *Akron*, 462 U.S. at 443, 103 S. Ct. at 2499). Viewed in this light, the provision at issue here may, like that in *Thornburgh*, "require[ ] the dissemination of information that is not relevant to such consent, and thus, it advances no legitimate state interest." *Id.* at 2180.

Another aspect of the counseling requirements is troubling. Section 205.730(b)(2)(D) requires that "counselors shall have no financial interest in the patient's decision." We find it impossible to read this provision in such a way that it does not, at least in some cases, preclude the performing physician from providing the counseling. This, we believe, is fundamentally at odds with the emphasis placed on the patient-physician relationship by *Roe* and its progeny. The woman desiring an abortion, according to those cases, is to reach that decision in consultation with "her responsible physician." *Roe*, 410 U.S. at 153, 93 S. Ct. at 727; *cf. Akron*, 462 U.S. at 449, 103 S. Ct. at 2502 (striking down a requirement that the attending physician, rather than other professionals, *must* provide the requisite counseling). The state cannot preclude that dialogue, or demand that others be a party to it merely because the physician has a "financial interest" in the woman's decision. In all other areas of medicine, the state relies on the physician's professional and ethical obligations to prevent his "financial interest" from clouding his perspective to the detriment of his patient. It may not do otherwise merely because an abortion decision is involved. *See Doe v. Bolton*, 410 U.S. 179, 197-200, 93 S. Ct. 739, 750-51 (1973). In *Doe*, the Court struck down requirements that an abortion be approved by a hospital abortion committee and by two other physicians independent of the woman's own consulting physician because, *inter alia*, the state required such additional approval for "no other voluntary

medical or surgical procedure. . . ." According to the Court:

> If a physician is licensed by the State, he is recognized by the State as capable of exercising acceptable clinical judgment. If he fails in this, professional censure and deprivation of his license are available remedies. Required acquiescence by co-practitioners has no rational connection with a patient's needs and unduly infringes on the physician's right to practice.

Id. at 199, 93 S. Ct. at 751.

We believe those principles are equally applicable here. Accordingly, we hold that the requirement that counseling be conducted by one who has no "financial interest" in the patient's decision is unconstitutional.

D.

Of the requirements applicable to ASTCs generally, the physical plant equipment and staffing requirements, in particular, seem totally unjustified from a medical standpoint. The testimony regarding many of the physical plant requirements makes clear that they have "no medical justification whatsoever" when applied to first and early second trimester abortions of the type involved in this case.

According to the testimony, the minimum size requirements for examination rooms, procedure rooms, recovery rooms, and corridors and doors not only are not "medically necessary," but do not enhance the safety of the abortion procedure "in any way" and do not have "any medical justification." R. Vol. I at 263-72 (testimony of Dr. Hern); *see also* R. Vol. I. at 154 (testimony of Dr. Ragsdale) (large procedure room "not only medically unnecessary but medically poor"). We agree that the requirements that ASTCs performing first and early second trimester abortion(s) be "the functional equivalent of small hospitals" are not sufficiently justified by "important state health objectives" to be sustained.

Additionally, the ventilation requirements of the regulations, which require specific air pressure relationships between rooms and specific air change ratios are unrelated to the safety of first and early second trimester abortions. The purpose of such requirements is to prevent infection from airborne bacteria. All of the medical experts, including defendants', testified that airborne bacteria simply is not relevant to the procedures involved in this case, because the procedures do not involve an incision. The sole testimony to the effect that such requirements might be advisable came from the State's architectural expert, who apparently believed that an incision was required. It can scarcely be doubted that such a witness lacks any expertise to enable him to form an opinion regarding the medical justification for a particular requirement.[12]

More importantly, perhaps, the defendants failed to adduce any evidence at all of a medical justification for the physical plant requirements. Although the defendants protest on appeal that plaintiffs' experts who testified as to the lack of medical justification were not building and construction experts, the relevant test is whether the standards are "justified by important state health objectives." It seems clear to us that medical experts can offer testimony relevant to that standard, and it is questionable whether those without a health care background can. As we have noted above, only defendants' architectural expert testified as to the need for the ventilation requirements. This witness similarly testified regarding room sizes, although he stated that the requirements were drafted with procedures involving general anesthesia in mind. At one point, he testified that he relies on the

[12] Defendants' medical expert, Dr. Barton, lacked significant experience performing first trimester abortions. Those which he did perform were generally performed under a general anesthetic in a hospital setting. Due to his lack of experience relevant to the procedures at issue in this case, the district court properly accorded his testimony little weight. Defendants similarly do not rely on it heavily in this court.

physician operating a facility to determine what is medically required. Linder Dept. at 42.

The structural, equipment, and staffing requirements of the regulations are quite similar to those invalidated in *Reizen*. *See* 743 F.2d at 364-65. They also bear a remarkable resemblance to the abortion-specific scheme we invalidated in *Friendship*. While the evidence in *Reizen* indicated a per-patient cost increase considerably greater than that in this case (*Friendship* did not consider particularized cost estimates), the regulations there, as here, would have required considerable up-front expenditures. Also, as we have noted above, per-patient financial cost is not the only relevant burden. We have little trouble concluding that these requirements, which impose a substantial burden and are not justified by health objectives, are unconstitutional.

E.

We also believe that the "certificate of need" proceeding requirement of the Health Facilities Planning Act is unconstitutional. The only interest which the State has articulated is the desire to keep costs down under the "cost-plus" disbursement method which was at one time used by the State in making certain health care payments for its residents. Apart from the fact that this interest no longer exists because the State has discontinued use of this method, the State has never made such payments for abortions. Furthermore, the interest cannot be said to be compelling in any event. While a state may have some interest in preventing wasteful duplication of resources, the interest must give way where the exercise of constitutional rights is concerned. Certainly it would be unconstitutional for a state to require that anyone desiring to publish a newspaper demonstrate "need" for the publication, though it can scarcely be gainsaid that at least some few involve wasteful duplication. Where the exercise of constitutional rights is concerned, the government may play no role in determining whether outlets for their exercise are "needed."

The unconstitutionality of the "certificate of need" proceedings as applied to ASTCs that wish to perform abortions is exacerbated by the failure of the State to prevent the process from becoming essentially a public veto of the ASTCs' existence. As we noted above, the proceedings attended by the individual plaintiff physician was allowed to degenerate into a shouting match between abortion foes and advocates of free choice. The State's unwillingness or inability to confine the proceedings to its even arguably legitimate goals bolsters our conclusion that this requirement cannot stand because it is not justified by any legitimate State interest.

V

While, as we have noted above, there may well be facets of the statute and regulations which would individually pass constitutional muster, *supra* nn. 8 & 11, we are constrained to affirm the district court's injunction of the scheme as a whole. Defendants, citing *Zbaraz v. Haritgan*, 763 F.2d 1532, 1545 (7th Cir. 1985), *appeal pending*, No. 85-673 and *Charles I*, 627 F.2d at 779, urge that we specifically analyze each provision and sever those portions which are unconstitutional. However, in neither *Zbaraz* nor *Charles I* were we confronted with a comprehensive scheme which either applied or not depending on whether a licensing requirement could stand. In *Zbaraz*, we noted that severability applies only to "any provisions which can be given effect without the invalid provisions," and that "severance is improper if the unconstitutional provision is 'an integral part of the statutory enactment viewed in its entirety.' " 763 F.2d at 1545 (quoting *Scheinberg v. Smith*, 659 F.2d 476, 481 (5th Cir. 1981)). Here, where we are dealing with a licensing scheme and the provision for separate licensure is itself invalid, not only can none of the other provisions "be given effect without the invalid provisions," but the licensing provision is certainly "an integral part" of the scheme as a whole. Additionally, in neither *Zbaraz* nor *Charles I* was the scheme

already so riddled with exceptions resulting from judicial decisions and non-enforcement policies as to be unintelligible. In such circumstances, we simply "cannot untangle the constitutional from the unconstitutional provisions. . . ." *Mahoning Women's Center v. Hunter*, 610 F.2d 456, 460 (6th Cir. 1979), *vacated on other grounds*, 447 U.S. 918, 100 S. Ct. 3006 (1980).

As originally written, the statute and regulations represented at least a coherent, if unconstitutional, whole which regulated all aspects of abortion practice in Illinois. However, as a result of various judicial decisions, and the defendants' change of enforcement policies in response to them, the scheme has long since lost that coherence. The statute and regulations as written bear very little resemblance to the way they are currently enforced. As is clear from portions of our opinion, we have at times encountered considerable difficulty discerning just what the law in Illinois is. Yet, the State expects physicians, on pain of professional censure (possibly including loss of their licenses) and a $10,000 a day fine, to divine the contours of the rules under which they must operate.

Under these circumstances, we fully agree with the Sixth Circuit's decision in *Mahoning Women's Center*. There, in invalidating, in its entirety, a local ordinance that required "the functional equivalent of a hospital" for first trimester abortions, the court held "[i]n this situation, we do not believe a useful purpose would be served by attempting to rewrite the minor provisions of the ordinance in order to make them constitutional." 610 F.2d at 461. We could not agree more.

Accordingly with the exception of the portion of the injunction regarding the second trimester hospitalization requirement, which is VACATED AS MOOT, the preliminary injunction is

AFFIRMED.

COFFEY, *Circuit Judge*, dissenting. A decade and one-half ago the Supreme Court announced "that the right of personal privacy includes the abortion decision, but that this right is not unqualified and must be considered against important state interests in regulation." *Roe v. Wade*, 410 U.S. 113, 154, 93 S.Ct. 705, 727 (1973). Today, under the guise of protecting the woman's constitutional privacy rights, the majority holds that the State of Illinois' health services statutory scheme, enacted in an attempt to regulate the ever-escalating costs of medical care without sacrificing its citizens' health and safety, is unconstitutional. Specifically, now some 14 years after its enactment, the majority declares the Ambulatory Surgical Treatment Center Act, 111½ Ill. Rev. Stat. ¶¶ 157-8.1 *et seq.* (the "ASTCA" or the "ASTC Act") and the regulations promulgated thereunder unconstitutional, holding that the State may not require licensure of facilities devoted primarily to performing semi-complicated (minor) surgery, including first-trimester abortions. As an alternative approach, the majority chooses and carves out a select few ASTC regulations among various others, discusses their validity, and then proceeds to invalidate those regulatory sections of the ASTC Act that apply to first-trimester abortion facilities in Illinois, stating that it was unable to sever those provisions of the Act it deemed unconstitutional from those that were constitutional. Thus, the majority strikes down the ASTCA and baldly asserts that "the [statutory] scheme has long since lost . . . coherence." Unfortunately, it is the majority's decision, rather than the Illinois legislative scheme, that lacks coherence.[1] I am convinced that under *Roe* and its

[1] The majority's precise holding is confusing. On the one hand, the majority affirms the district court's preliminary injunction which only enjoined Illinois from regulating ASTCs to the extent those facilities were performing abortions. On the other hand, the majority apparently strikes down not only § 16(1) of the MPA, but the ASTCA and the IHFPA as well, stating it could not "untangle the constitutional from the unconstitutional," and further asserts that specific substantive aspects of the statutes and regulations are unconstitutional and "render the scheme unconstitutional as a whole."

progeny that the individual states have the authority to ensure that all surgical procedures, including first-trimester abortions, are performed "under conditions insuring maximum safety for the woman." *Connecticut v. Menillo*, 423 U.S. 9, 11, 96 S.Ct. 170, 171 (1975) (per curiam). Certainly states have the power and authority, if not the duty, to apply the same licensing standards to abortion facilities as those applied to facilities performing similar surgical procedures.[2] I know of no law to the contrary.

Moreover, the majority decision ignores the legislative intent and the historical context of the enactment of the challenged provisions: section 16(1) of the Medical Practice Act (the "MPA"), 111 Ill. Rev. Stat. ¶ 4433(1); the Ambulatory Surgical Treatment Center Act, 111½ Ill. Rev. Stat. ¶¶ 157-8.1, *et seq.*, and the regulations promulgated thereunder; and the Illinois Health Facilities Planning Act, 111½ Ill. Rev. Stat. ¶¶ 1151, *et seq.*, particularly ¶¶ 1155-1160. Research reveals that the Illinois legislature enacted § 16(1) of the MPA[3] intending to limit the performance of abortions only to licensed ambulatory surgical treatment centers, hospitals, or similar facilities and expressed such intention by requiring licensure of "any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose," (definitions section—

[2] As demonstrated, *infra*, the most significant undisputed fact in the record is that an abortion, regardless of the trimester in which it is performed, is considered a surgical procedure, albeit a minor surgical procedure, accompanied all too frequently by concomitant medical, physical, and psychological complications.

[3] As noted by the majority, § 16(1) of the MPA "allows for revocation or suspension of the license of any physician *who performs an 'elective abortion' in any place other* than a licensed Ambulatory Surgical Treatment Center (ASTC), a hospital, or a facility run by the state or federal governments." (Emphasis added.)

ASTCA, ¶ 157-8.3(A)).[4] However, the legislature's primary purpose for enacting the *Ambulatory Surgical Treatment Center Act* was to regulate and prescribe safeguards for the rapidly developing trend of cost-effective ambulatory surgical medical services. The majority unfortunately disregards this primary purpose which provided the impetus for the enactment of the ASTCA and through mere speculation holds that the ASTCA is solely an abortion statute. Further, in its determination to do away with the duly enacted legislation, the majority completely disregards the statute's severability clauses as if they didn't exist, stating it could not "untangle the constitutional from the unconstitutional" and thus refuses to give effect to the challenged acts.[5] Rather than recognize and effectuate the true intent and legitimate purpose of the acts and enjoin only those provisions which might impinge on a woman's limited right to terminate her pregnancy (§ 16(1) of the MPA, its companion clause in ¶ 157-8.3(A) and § 205.730(b)(2)(D) of the ASTCA regulations), the majority, in over-expansive language, declares, " '[W]e do not believe a useful purpose would be served by attempting to rewrite minor provisions of the ordinance [in this case

[4] ¶ 157-8.3 provides:

> "(A) 'Ambulatory surgical treatment center' means any institution, place or building devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures *or any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose.* Such facility shall not provide beds or other accommodations for the overnight stay of patients. Individual patients shall be discharged in an ambulatory condition without danger to the continued well being of the patients or shall be transferred to a hospital."

(Emphasis added to highlight the clause included in the ASTCA restricting the availability of an abortion.)

[5] The severability clauses of the MPA, ASTCA, and the IHFPA are found respectively at 111 Ill. Rev. Stat. ¶ 4458, 111½ Ill. Rev. Stat. ¶ 157-8.15, and 111½ Ill. Rev. Stat. ¶ 1166.

the statutes and regulations] in order to make them constitutional.' " In so holding, the majority improperly substitutes its judgment for that of the legislature which enacted the statute because of its concern for the safety of its citizens. In the end, the majority decision severely limits (or casts aside) the state's ability to implement cost-effective schemes and regulate rapidly developing and modern methods of providing medical services simply because abortion (surgical) procedures may be involved. The majority's misdirected holding ultimately protects only the financial interests of abortion providers, like Dr. Ragsdale, rather than following the Supreme Court's limited mandate in *Roe* aimed at protecting the patient's privacy rights. If we allow the majority's "reasoning" to stand, surgeons, as well as other ASTC operators whose facilities are devoted primarily to the performance of abortions, will be allowed to operate without regulation while those ASTCs primarily performing other types of minor surgical procedures will remain regulated (assuming the majority's decision merely affirms the district court's preliminary injunction). Thus having treated facilities devoted *primarily* to abortions differently from those facilities *primarily* devoted to other surgical procedures, the majority carves out an "abortionist exception" to the general rule that states can reasonably regulate how medical services are provided to its citizens. Ultimately, the majority in effect creates a legal vehicle for the non-abortionists primarily performing other surgical procedures to challenge the ASTCA on equal protection grounds; for what rational basis exists for regulating ambulatory surgical centers differently than those facilities, like Ragsdale's abortion enterprise, devoted primarily to the termination of pregnancies?

The task of a reviewing court, contrary to the majority's reasoning, is, "of course, . . . to resolve the issue by constitutional measurement, free of emotion and predilection." *Roe v. Wade*, 410 U.S. at 116, 93 S.Ct. at 709. Consistent with this Supreme Court directive, our decision must neither reflect pro choice nor anti-abortion sen-

timent. The Illinois legislation at issue, specifically the ASTCA, is fundamentally different from other Illinois abortion-related legislation and merits thorough, reflective, and separate consideration. I would enjoin § 16(1) of the MPA and sever and further enjoin its companion clause in ¶ 157-8.3(A) of the ASTCA requiring licensure of "any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose" because these provisions prevent a physician from performing a first-trimester abortion in his or her office. Under *Roe* and its progeny this prohibition may very well be considered unconstitutional. I am convinced that the states, including Illinois, are free to regulate ambulatory surgical treatment centers, including those performing abortions, as long as abortions are not singled out from other, similar surgical procedures, subject only to the well-known rational basis test governing social and economic legislation. Under the rational basis test the ASTCA and IHFPA are constitutional. Consistent with this analysis, I further evaluate the remaining abortion-specific statute sections and regulations[6] promulgated thereunder under the strict scrutiny test articulated in *Roe* and its progeny[7] and would hold all but one of these constitutional because these statutory sections and regulations neither burden the abortion deci-

[6] For example, ¶ 157-8.6-1 of the ASTCA requires that any corporation operating an ASTC "devoted primarily to providing facilities for abortion" must have a licensed physician who is "actively engaged in the practice of medicine at the Center, on the board of directors as a condition of licensure." Additionally, subpart G of Title 77 of the Illinois Administrative Code contains abortion-specific regulations. The validity of all but one of these provisions is demonstrated, *infra*.

[7] I concur with the majority that the challenge to the second-trimester hospitalization requirement is moot. It appears that the majority effortlessly utilized and applied the severability clause of the Act to the second-trimester hospital requirement, but lost this analytical ability with respect to the other challenged provisions.

sion nor its effectuation, and are justified with important health objectives in mind.

When the alleged "tripartite" legislative scheme is thus analyzed, neither a woman's right to terminate her pregnancy, nor the state's right to rationally regulate modern medical services for the protection of its citizens is adversely affected. Thus, I would reverse the district court's order enjoining Illinois' health services laws, except to the extent it enjoined § 16(1) of the Medical Practice Act, its companion clause in ¶ 157-8.3(A) of the ASTCA, and § 205.730(b)(2)(D) of the ASTCA regulations.

I

The majority decision properly notes that the "statutory and regulatory scheme is somewhat complex," but then proceeds to further confuse the challenged acts and their interrelationships, completely disregarding the legislature's intent regarding the various acts. The record of the legislative history reveals that § 16(1) of the MPA, 111 Ill. Rev. Stat. § 4433(1), and the Ambulatory Surgical Treatment Center Act (ASTCA), 111½ Ill. Rev. Stat. ¶¶ 157-8.1, *et seq.*, were initially companion bills to the initial comprehensive Illinois Abortion Act (IAA), 38 Ill. Rev. Stat. ¶¶ 81-11, *et seq.*[8] The IAA, § 16(1) of the MPA, and the ASTCA, were Senate bills (S.B.) 1049, 1050, and 1051, respectively. The legislative history further reveals that S.B. 1049 and S.B.

[8] The initial Illinois Abortion Law, ¶¶ 81-11, *et seq.*, became effective July 19, 1973, but was subsequently repealed by the Abortion Law of 1975, effective October 30, 1979. The Abortion Law of 1975 has been challenged on more than one occasion. *See, e.g., Charles v. Carey*, 579 F.Supp. 464 (N.D. Ill. 1983), *aff'd in part, rev'd in part on other grounds, Charles v. Daley*, 749 F.2d 452 (7th Cir. 1984), *appeal dismissed sub nom. Diamond v. Charles*, 106 S.Ct. 1697 (1986). The initial IAA had a completely different purpose than the ASTCA and IHFPA. However, the majority confuses the purposes of the IAA from that of the ASTCA and IHFPA, and in doing so clouds its ability to analyze the challenged statutes and regulations.

1050 were integrally related; their purpose was to regulate abortions in Illinois in light of, and in an attempt to comply with, the Supreme Court's then-recent *Roe* and *Doe* decisions. As noted by the majority, § 16(1) of the MPA provided for the "revocation or suspension of the license of any physician who performs 'elective abortions' in any place other than a licensed Ambulatory Surgical Treatment Center (ASTC), a hospital, or a facility run by the state or federal governments." Apparently, members of the Illinois legislature were concerned that the State would eventually be responsible for the cost of abortions performed on indigents in hospitals, so to reduce the State's anticipated abortion costs, less-expensive ASTC facilities were included in the list of approved locations for the performance of pregnancy termination procedures. At the same time the legislature was debating the regulation of abortions, ASTCs were just coming into existence and thus not regulated. Thus, S.B. 1051, an independent health regulatory bill creating and regulating ASTCs, was made a companion bill to the abortion bills.

Contrary to the majority's assertions, the ASTCA, unlike the IAA and § 16(1) of the MPA, was not primarily enacted for the purpose of regulating abortions. The record and legislative history reveal that the ASTC Act became law in Illinois in 1973 with the express policy of insuring maximum safety in all medical procedures, providing:

> "for the better protection of the public health through the development, establishment, and enforcement of standards (1) for the care of individuals in ambulatory surgical treatment centers, and (2) for the construction, maintenance and operation of ambulatory surgical treatment centers, which, in light of advancing knowledge, will promote safe and adequate treatment of such individuals in ambulatory surgical treatment centers."

Ill. Rev. Stat. ch. 111½, ¶ 157-8.2. Further, the ASTCA was intended to regulate the cost-effective and rapidly developing ambulatory outpatient surgical medical services. The minutes of the March 7, 1974, Ambulatory Surgical Treatment Center Licensing Board meeting provide relevant historical facts relating to the enactment of the ASTCA:[9]

> "In July 1971 . . . a member of the hospital licensing board, was appointed chairman of a committee appointed to formulate regulations for those facilities that were presently unlicensable. Consideration was given to a large number of classifications and actually there were 32 types of health facilities listed. . . . On July 12, 1972, the final draft (after four drafts) of proposed standards were submitted to the Hospital Licensing Board. . . . [O]n August 16 [a member of the Board] sent these proposed regulations forward [to the legislation liaison]. . . . About August 1972 [the Board] began to get involved more with the

[9] The majority improperly relies on the ASTC Licensing Board minutes for the legislative intent of the act. The March 7, 1974, minutes conclude that "the legislation was written specifically for regulation of the performance of abortions." On this basis, the majority states, "First, we cannot ignore the fact that the ASTCA was enacted primarily with abortion clinics in mind and only applied to outpatient surgical clinics generally in an effort to save the statute from unconstitutionality." Initially *I point out that the district court specifically and properly rejected the plaintiff's request to admit the minutes of the licensing board meeting as proof of the legislature's intent.* Tr. at 616. The district court's evidentiary ruling was proper because "a court should adhere to the enacting legislature's purposes," Posner, *The Federal Courts*, p. 279 (1985), rather than post-enactment statements regarding legislative intent, particularly when those statements are not even made by the legislators involved. The district court received the licensing board minutes only for the limited purpose of establishing the Board's state of mind regarding its enforcement procedures. However, the historical facts regarding the development of the ASTC legislation and regulations are reliable, material, and relevant to understanding the historical context in which the ASTCA was enacted. Thus, I make limited reference to the minutes of the Board meeting only to draw attention to the historical facts contained therein.

question of abortions which became the primary target for discussion."

The significance of these Board minutes lies in the fact that as early as 1971 a state agency began preparing the proposed regulations in response to the changing needs and practices of medical services. Cost-effective "[f]reestanding ambulatory surgical centers (FASCs) are independent entities which first opened in 1970. . . . [T]hese facilities were conceived to fill a gap between the doctor's office and the hospital for minor surgical procedures not requiring overnight hospitalization." Note, *Freestanding Emergency Centers: Regulation and Reimbursement*, 11 Am. J. L. & Med. 105, 118 (1985).[10] "The first successful freestanding ambulatory surgery center (FASC), [well known as Surgicenter], was opened in February 1970 in Phoenix, Arizona." D. Ermann and J. Gabel, *The Changing Face of American Health Care, Multi-Hospital System, Emergency Centers, and Surgery Centers*, 23 Medical Care 401, 406 (May 1985). As early as 1976 one commentator observed:

> "From a societal point of view, perhaps the greatest impetus behind the ambulatory surgery concept is its potential for reducing the cost of services. This potential applies to both freestanding and hospital-based facilities, the two major prototypes for ambulatory surgery. By eliminating overnight hospital stays, expenditures for hospital services for inpatient health care, which now account for about 40 percent of our

[10] Much has been written regarding trends in ambulatory medical services, including ambulatory surgical treatment centers. *See generally* T. O'Donovan, *Ambulatory Surgical Centers, Development and Management* (1976); L. Burns, *Ambulatory Surgery, Developing and Managing Successful Programs* (1984); M. Roemer, *Ambulatory Health Services in America* (1981); D. Ermann and J. Gabel, *The Changing Face of American Health Care*, 23 Medical Care 401 (May 1985); Pavarini, *Setting Up and Operating Ambulatory Care Centers in a Competitive Environment*, 29 St. Louis U. L. J. 747 (1985).

> total national health expenditure, may be reduced directly and dramatically, at least on a short-term basis. By focusing on reducing inpatient surgery (accounting for 60 percent of all hospital expenditures and about 25 percent of total health care expenditures), ambulatory surgery may further reduce costs."

T. O'Donovan, *Ambulatory Surgical Centers, Development and Management*, p. 143 (1976). Further, by 1984 the ASTC trend was well established:

> "The success of the Phoenix center precipitated rapid growth of a new type of facility for the delivery of ambulatory surgery, the freestanding, independent, ambulatory surgery center. Since that time, the Surgicenter has become a model for an increasing number of both independent and hospital-sponsored freestanding ambulatory surgery programs.
>
> According to the Freestanding Ambulatory Surgical Association (FASA), there are approximately 125 independent freestanding ambulatory surgery centers, 86 of which are members of FASA. According to FASA, which has been keeping statistics on its members since 1974, the membership performed 94,499 ambulatory surgery procedures in 1981, an increase of 6 percent over the number performed in 1980. This figure can be compared to 3.2 million ambulatory surgical procedures performed by hospitals offering ambulatory surgery in 1980."

L. Burns, *Ambulatory Surgery, Developing and Managing Successful Programs*, pp. 11-12 (1984). Lastly, I observe that freestanding ambulatory surgical centers are properly subject to licensure and regulation (as are the vast majority of medical facilities performing surgeries) throughout the country, and not only in Illinois. One writer pointed out that:

> "a FASC must obtain a state CON [Certificate of Need] in order to build the facility. In some states FASCs must also seek accreditation. In Illinois, FASCs are licensed and regulated by the State De-

> partment of Public Health. In Minnesota, surgical centers are covered by licensing rules. They must be staffed and equipped to handle surgical procedures, anesthesia, and post-surgical care."

Note, *Freestanding Emergency Centers, Regulation and Reimbursement*, 11 Am. J. L. & Med. 105, 118 (1985).

Obviously the Illinois Legislature was not privy to all this information regarding ambulatory surgical treatment centers in 1973, at the time it enacted the ASTCA. However, as I stated, the record and legislative history reveal that the legislature was well aware of the new and fast developing medical trend in outpatient ambulatory care and specifically sought to regulate it. During the Senate debates, state Senator Wooten summarized S.B. 1051 as follows:

> "This is another one of those bills that cuts across lines in all kinds of ways. The Illinois State Medical Society asked that it be presented in a series with the two previous bills [S.B. 1049 and S.B. 1050], one changing the law relating to abortion, the other changing the Medical Practices Act. *While this has a relationship to abortion, it actually goes much beyond that. It [S.B. 1051] provides for the establishment and licensing of facilities which can perform minor surgery.* This would be things like tonsilectomy, hernias, abortions would be included, facial surgery, plastic surgery and so on. In other words procedures which would not require an overnight stay. And indeed these ambulatory surgical treatment centers are forbidden to keep patients overnight. However, those of you who have kept close to medical practices know that untoward things can occur at any time, and so provision is made in here that *doctors who function in such a center must also be licensed to practice in a hospital nearby so that if any complications occur they can quickly move the patient to that place.* Now, I handed out an outline to explain to you how these things would work, definitions, they must get

> a license, some of these things are left open as to regulations. The Department would like to take a hand in that. *This is something doctors have been urging us to do for a couple of years now, and ambulatory surgical treatment centers are . . . in effect out west. The idea is that they can be a great saving to a patient.* One of the big costs in a hospital, if you remember it's kind of like a hotel which has special services and if you don't need that overnight stay, you can save a great deal of money. So there's a great savings possible for the patient who needs this kind of one-day surgical treatment. *It does include abortion, and everything would be rather closely regulated and inspected.*"

(Emphasis added). Another state senator further pointed out that:

> "This bill is a good bill. It's not related in any way to abortions. It's sponsored by the Medical Association. There's nothing wrong with ambulatory medical services."

Thus, contrary to the majority's mere speculative assertions, the legislative history clearly and unequivocally supports the proposition that the ASTCA was not enacted primarily to regulate abortions, but rather for the regulation of all semi-complicated (minor) surgical procedures performed in the rapidly developing ambulatory surgical treatment centers. Finally, I observe that just prior to the ASTCA's enactment, Senator Wooten specifically stated: "The *main thrust of [S.B. 1051] is to try to save some money by getting minor surgical treatment out of the hospital where it is hideously expensive and into a clinic.*" (Emphasis added).

The record and the legislative history further reveal that the Illinois Health Facilities Planning Act (IHFPA) was enacted one year after the enactment of § 16(1) of the MPA and the ASTCA and was clearly not part of a "tripartite" legislative scheme to limit the availability of abortions. The legislative history of the IHFPA reveals

that it neither mentions abortions, nor referred to them, nor was it enacted for purposes of regulating abortions. The IHFPA was intended to address the problem of expensive, overexpanded and underpopulated medical facilities and underutilized medical equipment in the State of Illinois. In the words of a legislator, the IHFPA was to

> "provide a means *for proper planning with local input and decision making to cut down on empty hospital facilities*, nursing home facilities, sheltered care . . . facilities and . . . *ambulatory surgical facilities.*"

(Emphasis added).

Thus, the legislative history of the acts supports the valid premise that the legislature intended to regulate abortions when it enacted the Illinois Abortion Act. It also appears that section 16(1) of the MPA and its companion clause in ¶ 157-8.3(A) of the ASTC were probably enacted to prevent abortions from being performed in a physician's office. On the contrary, there is no proof in this record that either the ASTCA or the IHFPA were enacted primarily to regulate abortions; rather, these laws were adopted to regulate the delivery of medical services to its citizens and to attempt to prevent and control the further unnecessary overexpansion of Illinois' medical facilities. That the ASTCA was initially a companion bill to the abortion bills is more of a historical coincidence relished by political opportunists who, in this case, apparently fully utilized it to their advantage. As the minutes of the licensing board reflect, for whatever their worth: "Without the public interest in abortions, we would not have any of the present legislation." That is to say that the state legislators and other interested parties who were primarily interested in regulating ambulatory medical services would not have been able to enact the legislation without the statewide and even nationwide interest in the abortion question at the time.

The majority, acting and reasoning as if living in a social and economic vacuum (overlooking the developing nationwide trend of ASTCs), ignores the dual purpose of the

legislative scheme presently at issue, selectively carving out the regulatory motive of the ASTCA to support its abortion theory of enactment. Thus, the majority states: "As originally written, the statute [I assume the ASTCA] and regulations represented at least a coherent, if unconstitutional, whole which regulated all aspects of abortion practice in Illinois." Having ignored or at least overlooked the State's legitimate intent to regulate the new and rapidly developing trend of ambulatory surgical medical services, the majority treats the ASTCA and the regulations promulgated thereunder as "minor" abortion provisions. Further, the majority rejects the basic principle of severability when interpreting the construction of a duly adopted legislative enactment which should give effect to the State's legitimate purposes; and thus fails to apply the correct legal standard to the different acts and regulations and affirms the preliminary injunction. Thus, the majority limits and fails to effectuate the legitimate legislative purposes behind the ASTCA. As a noted commentator has observed, limiting the scope of a legislature's intent constitutes undesirable judicial activism as much as a decision construing a statute beyond its intended scope. *See* Posner, *Statutory Interpretation, in the Classroom and in the Courtroom*, 50 U. Chi. L. Rev. 800, 822 (1983). The majority's failure to give full effect to the real and legitimate legislative intent to regulate ASTCs is the basis of my dissent.

Recently, this court observed:

> "In *Immigration and Naturalization Service v. Chadha*, 462 U.S. 19, 103 S.Ct. 2764, 77 L.Ed.2d 317 (1983), the Supreme Court stated that unconstitutional provisions in a statute shall be severed if it appears that the legislature would have enacted constitutional provisions of the statute independently of those provisions. 103 S.Ct. at 2774 (citing *Buckley v. Valeo*, 424 U.S. 1, 108, 96 S.Ct. 612, 677, 46 L.Ed.2d 659 (1976))."

Zbaraz v. Hartigan, 763 F.2d 1532, 1545 (7th Cir. 1985), *aff'd*, 108 S.Ct. 479 (1987). The Illinois laws in question all have their own severability provisions; thus it is clear that the Illinois legislature intended that the constitutional provisions of the acts should be given effect even if other provisions were held unconstitutional. Accordingly, I analyze the challenged statutes and regulations recognizing that "severance is improper [only] if the unconstitutional provision is 'an integral part of the statutory enactment viewed in its entirety.' " *Id.* (quoting *Scheinberg v. Smith*, 659 F.2d 476, 481 (5th Cir. 1981)). On the other hand, the challenged provisions which burden a woman's right to privacy may be severed as long as the severed provisions do not affect "the essential purposes of the act." *Id.*

II

The abortionist, Dr. Richard M. Ragsdale, plaintiff-appellee, testified at the preliminary injunction hearing that the alleged "[f]irst and major burden [affecting a woman's right to terminate her pregnancy] is simply the requirement for an independent licensure as an abortion provider." This licensing requirement, applicable to any physician who wishes to perform an abortion outside of a hospital, an ASTC, or other regulated facility, regardless of the gestational period of the embryo or fetus, was created when the legislature enacted § 16(1) of the MPA and its companion clause in the ASTC definitions section. As previously noted by the majority, "[s]ection 16(1) of the Medical Practice Act . . . allows for revocation or suspension of the license of any physician who performs an 'elective abortion' in any place other than a licensed Ambulatory Surgical Treatment Center . . ., a hospital, or a facility run by the state or federal governments." The following clause in ¶ 157-8.3(A) of the ASTCA is the companion clause to § 16(1) of the MPA, and brought all surgeons who wished to perform abortions under the ASTCA licensing and regulatory scheme:

> " 'Ambulatory Surgical Treatment Center' means . . . any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose . . . ."

Significantly, the defendant-appellant, the State of Illinois, asserts that it no longer enforces § 16(1) of the MPA. Additionally, the majority observes that Illinois alleges that the clause in ¶ 157-8.3(A) above is no longer being enforced, noting that:

> "Since 1981, the [ASTC] act and regulations have been applied only to facilities which are primarily devoted to the performance of surgical procedures (including abortions). This enforcement policy was adopted in response to *Village of Oak Lawn v. Marcowitz*, 86 Ill.2d 406, 427 N.E.2d 36 (1981), which refused to enforce, in a criminal proceeding, that portion of the local ordinance which incorporated the ASTCA definition of an ASTC which covered 'any facility where a medical or surgical procedure is performed for the termination of pregnancy, regardless of whether the facility is primarily devoted to that purpose.' "

The majority holds, and I agree, that Illinois' alleged nonenforcement policy does not render the issues moot.

Although several justices have persuasively argued that *Roe v. Wade* and its progeny articulate an "unworkable scheme for constitutionalizing the regulation of abortion," *Thornburgh v. American College of Obstetricians*, 476 U.S. 747, 814, 106 S.Ct. 2169, 2207 (1986) (Justice O'Connor, dissenting), or represent a "venture . . . fundamentally misguided since its inception," *Id.* at 786, 106 S.Ct. at 2192 (Justice White, dissenting), this court should be bound by *Roe* and its progeny. The Supreme Court's recent *Thornburgh* decision "reaffirm[ed] the principles laid down in *Roe* and *Akron*." *Id.* at 759, 106 S.Ct. at 2178. Thus, we analyze the abortion licensing requirement created when the Illinois legislature enacted § 16(1) of the MPA and its companion provision contained in the ASTC definition of

ambulatory surgical treatment center, ¶ 157-8.3(A), under the standards articulated in *Roe* and its progeny.

> "In *Roe v. Wade*, the Court held that the 'right of privacy, . . . founded in the the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy.' . . .
>
> * * * *
>
> The Court also has recognized, because abortion is a medical procedure, that the full vindication of the woman's fundamental right necessarily requires that her physician be given 'the room he needs to make his best medical judgment.' . . .
>
> At the same time, the Court in *Roe* acknowledged that the woman's fundamental right '*is not unqualified and must be considered against important state interests in abortion.*' . . . But restrictive state regulation of the right to choose abortion, as with other fundamental rights subject to searching judicial examination, must be supported by a compelling state interest. . . . [The Supreme Court] recognized two such interests that may justify state regulation of abortions.
>
> *First, a state has an 'important and legitimate interest in protecting the potentiality of human life.'* . . . Although this interest exists 'throughout the course of the woman's pregnancy,' . . . it becomes compelling only at viability, the point at which the fetus 'has the capability of meaningful life outside the mother's womb.' . . .
>
> Second, because *a State has a legitimate concern with the health of women who undergo abortions, 'a State may properly assert important interests in safeguarding health [and] in maintaining medical standards.'* . . . [The Court further] held in *Roe*, however, that this health interest does not become compelling until 'approximately the end of the first trimester'

> of pregnancy. . . . Until that time, a pregnant woman must be permitted, in consultation with her physician, to decide to have an abortion and to effectuate that decision 'free of interference by the State.'
>
> *This does not mean that a State never may enact a regulation touching on the woman's abortion right during the first weeks of pregnancy. Certain regulations that have no significant impact on the woman's exercise of her right may be permissible where justified by important state health objectives. . . .*
>
> From approximately the end of the first trimester of pregnancy, the State 'may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health.' . . . The State's discretion to regulate on this basis does not, however, permit it to adopt abortion regulations that depart from accepted medical practice. [The Court has] rejected a State's attempt to ban a particular second trimester abortion procedure, where the ban would have increased the cost and limited the availability of abortions without promoting important health benefits. . . . *If a State requires licensing or undertakes to regulate the performance of abortions during this period, the health standards adopted must be 'legitimately related to the objective the state seeks to accomplish.'* "

City of Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 426-431, 103 S.Ct. 2481, 2490-93 (1983) (citations omitted) (emphasis added).

Initially one observes that the abortion licensing requirement as it exists pursuant to § 16(1) of the MPA and the ASTCA definition, fails to distinguish between first and second trimester abortions; thus, it prohibits the performance of first-trimester abortions in physicians' offices. The record reveals that a woman's qualified right under *Roe* to terminate her pregnancy is very probably impermissibly burdened because surgeons who would otherwise perform first-trimester abortions out of their offices are

precluded from doing so. Dr. Ragsdale, an abortionist and a board-certified obstetrician and gynecologist, testified that outpatient abortions, whether performed in a physician's office or a clinic, were as safe as an abortion performed in a hospital setting.

Plaintiffs additionally called another alleged abortion expert, Dr. Warren Martin Hern, a doctor and general practitioner without board certification in the specialty of obstetrics and gynecology. Hern testified that first-trimester abortions, performed six to eight weeks from the last menstrual period are "probably the safest surgical procedure being performed in the United States in this category of procedures."[11] Dr. Hern further testified that the safest surgical method of first-trimester abortion was the "vacuum aspiration" method. This procedure is basically "a suction removal of the uterine contents."[12]

The State of Illinois' expert, Dr. John J. Barton, a board-certified specialist in the fields of obstetrics and gynecology, also testified that first-trimester abortions performed in outpatient facilities (such as physicians' offices or ASTCs) present no greater risk than the risks and complication

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[11] Dr. Hern defined "in this category of procedures" as "procedures that involve invasion of a body cavity or a major organ of some kind."

[12] Dr. Hern noted that the fatality rate for abortion was about five per one million, whereas, the case fatality rate for term delivery was about 11 per 100,000 live births, which meant that the risk of term birth is approximately 25 times greater in terms of risk of death than abortion. Dr. Hern compared the abortion surgery risk factors to the risk factors of other types of outpatient surgery. He testified that "some estimates . . . indicate tonsillectomies are at least twice as dangerous as abortions." Similarly, Hern stated only that he consulted a colleague who informed him that laparoscopic surgery resulted in a death rate of two per 100,000. Hern testified: "Laparoscopic surgery involves the introduction of a laparoscope into the abdominal cavity. A laparoscope is a tube, a metal tube, that is hollow and is something that permits the physician to look through it into the cavity and is introduced through the umbilicus, with or without operating instruments."

rates of abortions performed in hospitals. Based on the medical experts' testimony, it appears probable that first-trimester abortions could be safely performed in the surgeon's office. Thus, it appears that § 16(1) and its companion clause in ¶ 157-8.3(A) of the ASTCA would limit the availability of abortions by precluding the performance of abortions in a physician/surgeon's office.

In *Akron* the Supreme Court noted that where the abortion law "increased the cost and limited the availability of abortions," such a law would probably interfere with the woman's decision to have an abortion as well as its effectuation. *Akron*, 103 S.Ct. at 2492-93. Further, although dictum, the Supreme Court noted "that the medical evidence suggests that until approximately the end of the first trimester, the state's interest in maternal health would not be served by regulations that restrict the manner in which abortions are performed by a licensed physician." *Id.* at 2492 n.11. The Court further observed that "uncomplicated abortions generally may be performed in a physician's office or an outpatient clinic up to 14 weeks from the first day of the last menstrual period." *Id.* (American College of Obstetricians and Gynecologists (ACOG), Standards for Obstetric-Gynecologic Services 54 (5th ed. 1982)). In light of the Supreme Court's caveat in *Akron* noting the probability that physicians can perform first-trimester abortions in their offices; given the defendant's policy of nonenforcement regarding § 16(1) of the MPA and its companion clause in the ASTC, ¶ 157-8.3(A), requiring the licensure of any facility performing even one abortion; and after evaluating the evidence presented during the preliminary injunction hearing which established that first-trimester abortions performed in a controlled outpatient setting, including a physician's office, probably were as safe as abortions performed in hospitals, I would selectively enjoin the enforcement of § 16(1) of the MPA and its companion clause in the ASTCA definition without destroying the entire act because it is more likely than not that the plaintiffs would prevail on the merits in light of present Supreme Court precedent.

In so holding, I agree with the Illinois Supreme Court decision in *Village of Oak Lawn v. Marcowitz*, 86 Ill. 2d 406, 427 N.E.2d 36 (1981), which also held that the ASTCA definition was constitutionally invalid as incorporated in a local ordinance which "closely resemble[d] the state [ASTC] act and implementing regulations adopted by the Department of Health." *Id.* at 38. The local ASTC ordinance also required an "initial license fee of $5,000, plus annual renewal fees of $2,000." *Id.* at 39. In *Marcowitz* the Illinois court, foreshadowing the caveat in *Akron*, stated:

> "Given the substantial licensing fee required and the detailed regulation involved, it seems inevitable that medical practitioners who might otherwise perform abortions for their regular patients, but whose facilities were not primarily devoted to surgery, would choose not to qualify under the ordinance. The right of a woman considering a first-trimester abortion to seek the advice and services of her obstetrician, gynecologist, or other physician in whom she has trust and confidence may not be so drastically curbed."

Id. at 42.

Further, both § 16(1) of the MPA and the impermissible definition clause in the ASTCA,[13] can easily be severed from their respective acts without affecting the legislature's "essential purposes" for the acts' enactments. *See Zbaraz*, 763 F.2d at 1545. The MPA is virtually unaffected and capable of being enforced independently of § 16(1) and as such will continue to be used *inter alia* to revoke or suspend a malfeasant physician's license. Similarly, the ASTCA becomes "abortion neutral" once the invalid clause is removed from the definition of an ASTC. *See,*

[13] The unconstitutional clause of ¶ 157-8.3(A) of the ASTCA to be severed reads as follows:

> "or any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose."

e.g., Village of Oak Lawn v. Marcowitz, 427 N.E.2d at 42.[14] So construed, the ASTCA fully effectuates the legislature's primary purpose for its enactment, i.e., to regulate the rapidly developing trend of cost-effective ambulatory surgical medical units. Thus, the State of Illinois remains free to license any facility pursuant to the "abortion neutral" ASTCA "devoted primarily to the maintenance and operation of facilities for performance of surgical procedures," including an abortion facility, like Dr. Ragsdale's, devoted *primarily* to the performance of abortions.[15] As with other social and economic legislation, the test traditionally applied is whether or not the law has a "rational relation" to a valid state objective. *See Williamson v. Lee Optical Company*, 348 U.S. 483, 491, 75 S.Ct. 461, 466 (1955). Thus, I would apply the "rational relation" test to the now "abortion neutral" ASTCA.

The majority, however, disagrees and would apply the strict scrutiny test relying on mere dictum in *Friendship Medical Center Ltd. v. Chicago Board of Health*, 505 F.2d 1141 (7th Cir. 1974), *cert. denied*, 420 U.S. 997 (1975). There the court observed:

> "Furthermore, any proposed regulation, even if applied universally to all similar medical procedures,

[14] As I discuss, *infra*, the abortion-specific ¶ 157-8.6-1, as well as the abortion-specific regulations, are also severable; however, all but one of these provisions survive the strict standard articulated in *Roe*.

[15] The majority baldly asserts that Dr. Ragsdale's practice consists exclusively of first-trimester abortions even though the record reveals that Ragsdale performed some 40,000 abortions between 1973 and 1985. Up until the Illinois court's 1982 decision in *Poe v. Illinois Department of Public Health*, No. 78-C-4126 (N.D. Ill. 1982), which found the second-trimester hospital requirement unconstitutional, Ragsdale limited his practice to the performance of first-trimester abortions. However, Ragsdale testified that subsequent to *Poe*, he began performing second-trimester abortions. This obviously makes economic sense since the physician had the available licensed ASTC and would only lose income by refusing to perform second-trimester abortions.

> because of the fundamental right of a woman to procure an abortion during the first trimester, would have to meet a compelling governmental interest requirement. Thus, any general health regulations which would apply to first-trimester abortions would have to be limited so as to give effect to the fundamental rights as established by *Roe* and *Doe*; that is, not be burdensome on a woman's right to decide to abort a pregnancy. By this we mean that in all probability nothing broader than general requirements as to the maintaining of sanitary facilities and general requirements as to meeting minimal building code standards would be permissible."

Id. at 1153-54.

Initially, I point out that Judge Fairchild, concurring, rejected the *Friendship* majority's dictum, stating:

> "Nevertheless, regulation of the safety of all these procedures, incidentally including first-trimester abortions, through imposition of generally applicable regulations, would seem to be a valid exercise of the state's interest in protecting health and need only satisfy the traditional [rational basis] test of judicial scrutiny imposed in this area."

Id. at 1155 (Fairchild, J., concurring). Because *Friendship*'s dictum to the contrary "was not refined by the fires of adversary presentation," it "was not a fully measured judicial pronouncement," and thus "not authoritative." *United States v. Crawley*, 837 F.2d 291, ___ (7th Cir. 1988). This caveat is particularly applicable here where we are construing a legislative act regulating a broad field of medical services, including minor surgical procedures.

The majority gives two reasons, unsupported by this record, for relying on the *Friendship* dictum: "First, we cannot ignore the fact that the ASTCA was enacted primarily with abortion clinics in mind and only applied to outpatient surgical clinics generally in an effort to save the statute from unconstitutionality." However, as I demonstrated in part I, the legislative history establishes the contrary; the primary purpose of the ASTCA was to regulate the new cost-effective ASTCs in which semi-complicated (minor) surgery was performed. In effect the majority puts the cart before the horse because it rests its analysis of the ASTCA on the quagmire of legal dictum set forth in *Friendship* which ultimately clouds and confuses its analysis of the ASTCA.

The majority further states:

> "Secondly, the state cannot, merely by applying the expedient and conclusory label 'surgery' to a medical procedure, apply requirements which would be necessary to major surgical procedures in the abortion context where they would be wholly inappropriate. It is as much a vice to treat abortion similarly to dissimilar procedures as it is to treat it differently from analogous procedures."

The majority's conclusory statement is incredible in light of the record. First of all, the plaintiff's own medical experts testified that an abortion was a surgical procedure (regardless of the type of abortion method used). On direct examination Ragsdale stated that an abortion "is a *minor surgical* procedure." Tr. at 420. Dr. Hern also testified that an early abortion—one performed six to eight weeks from the last menstrual period—"is the safest *surgical procedure* being performed." Tr. at 241 and 260. Likewise, it was Dr. Barton's expert opinion that an *abortion constituted an operation*, Tr. at 452, and abortions "are classified as minor surgical procedures." Tr. at 467. Dr. Hern further stated that an abortion is a surgical procedure categorized as a procedure "that involve[s] invasion of a body cavity or a major organ of some kind." Tr. at 241. In reaching its conclusion that the state applied the "expedient and conclusory label 'surgery' " to an abortion, the majority once again disregards the record and strays far afield from its area of legal competence and makes medical judgments and pronouncements that are more properly reserved to those expertly trained in the medical

scientific fields such as physicians, surgeons, nurses, medical technicians, etc.

Further, I observe that the courts have consistently alluded to abortions as a surgical procedure. In *Roe*, for example, Justice Stewart noted that the "protection of the health and safety of a woman" was a legitimate objective, amply sufficient "to permit a state to regulate abortions as it does other surgical procedures." *Roe v. Wade*, 410 U.S. at 170, 93 S.Ct. at 735 (Justice Stewart, concurring). Still more recently, in *Akron* the Supreme Court observed that the district court had found that "an abortion generally is considered a 'minor surgical procedure.' " *Akron*, 462 U.S. at 444, 103 S.Ct. at 2500 n.35. Thus, the evidence establishes that an abortion is a surgical procedure, albeit a semi-complicated (minor) surgical procedure. Significantly, the ASTCA was intended to regulate all *minor surgical procedures*, including all types of abortive procedures performed in an ASTC; this the majority fails to recognize. There is no reason to apply strict scrutiny in this situation. There is no language in the Supreme Court's decisions upholding the majority's speculative and implicit theory that the Court intended to strike down social and economic legislation such as the ASTCA in the name of *Roe* or a woman's limited right to terminate her pregnancy.

Further, in *Hodgson v. Lawson*, 542 F.2d 1350 (8th Cir. 1976) (per curiam), the court addressed the issue of whether a state could subject the abortion decision, even during the first trimester, to regulations promulgated by the state board of health, including licensing requirements. The Eighth Circuit concluded:

> "A state can impose the same regulations on a clinic, specifically built to perform abortions during the first trimester, that are imposed on other clinics that perform surgical procedures requiring approximately the same degree of skill and care as the performance of first-trimester abortions. As long as the regulations applying to abortion clinics are the same as those applied to other clinics performing similar surgical procedures, it would not be impermissible to make them specifically applicable to abortion clinics."

Id. at 1358.

Moreover, in *Baird v. Department of Public Health*, 599 F.2d 1098 (1st Cir. 1979), the court upheld a state licensure statute applicable to any clinic providing medical, surgical, dental, restorative, or mental hygiene services, including facilities offering only first-trimester abortion services. The First Circuit held: "*There is room under* ***Roe*** *for states to apply the same licensing standards to abortion facilities as they apply to like facilities performing medically analogous procedures.*" *Id.* at 1102 (emphasis added). *See also Westchester Women's Health Organization v. Whelan*, 475 F.Supp. 734, 739-40 (S.D.N.Y. 1979); *Abortion Coalition v. Michigan Department of Public Health*, 426 F.Supp. 471, 477 (E.D. Mich. 1977); *Hallmark Clinic v. North Carolina Department of Human Resources*, 380 F.Supp. 1153, 1157 (E.D.N.C. 1974), *aff'd on other grounds*, 519 F.2d 1315 (4th Cir. 1975). Thus, Illinois' laws licensing and regulating ASTCs are proper.

The law is very clear that a state has right to enact legislation for the protection of its citizens. *See Quilici v. Village of Morton Grove*, 695 F.2d 261, 274 (7th Cir. 1982) (Coffey, J., dissenting), *cert. denied*, 464 U.S. 863 (1983). The Supreme Court specifically stated:

> "It is elemental that a state has broad power to establish and enforce standards of conduct within its borders relative to the health of everyone there. It is a vital part of a state's police power. The state's discretion in that field extends naturally to the regulation of all professions concerned with health."

Barsky v. Board of Regents, 347 U.S. 442, 449, 74 S.Ct. 650, 654 (1954). Thus, I am persuaded by the logic of Judge Fairchild's concurrence in *Friendship*, rather than by the unsupported and speculative conclusions of the majority, as well as the reasoning of the First and Eighth Circuits, that under *Roe* and its progeny a state has not only the power and authority, but also the duty, to reg-

ulate all medical facilities, particularly any facility where any surgical procedures are performed (including first-trimester abortions) as a valid exercise of its interest in protecting the health and welfare of its citizens while ensuring that the facilities will provide "conditions insuring maximum safety for the woman" who has decided to terminate her pregnancy. *Connecticut v. Menillo*, 423 U.S. at 11, 96 S.Ct. at 171.

The ASTCA and the regulations promulgated thereunder were intended to do just that, to protect the safety of its citizens, and is reason sufficient enough to sustain the validity of the statute. As in many other surgical procedures, there are a variety of similar medical and physical risks involved in having an abortion. Depending upon a particular woman's characteristics and development, medical and psychological problems may very well arise during the abortion procedure that only an experienced, well-trained, board-certified obstetrician and gynecologist is capable of recognizing and effectively treating in a properly designed, constructed, equipped, maintained, managed and medically approved facility. Depending upon the gestational duration of the embryo or fetus, such complications include, but are not limited to, trauma, permanent damage to vital organs, dysfunction of the cardiovascular or respiratory system requiring cardio-pulmonary resuscitation, internal bleeding or hemorrhaging of the uterine wall, cervical lacerations, uterine perforation, embolism of the blood vessels, allergic reaction to medication or anesthesia, if administered, and even the permanent impairment of reproductive organs. Other medical factors that must be considered in making an informed abortion decision include the type of abortion to be performed (dilation and curettage, dilation and vacuum aspiration, dilation and evacuation, hysterotomy, or hysterectomy), the woman's medical history, her reaction to previous surgical procedures, her tolerance to certain medications, the chance that she is an RH-negative female, the likelihood of contracting a uterine infection, the chance that the placenta and fetus will not be completely

removed, the potential for future difficulties in bearing children, and also the possibility of sexual sterility. It defies reason to allow the state to license an ASTC performing hernia surgery, cataract removals, and repairs of a torn or detached retina, but not permit the state to license ASTCs primarily performing abortions when there are many similar risks involved in the myriad types of abortive procedures.

Lastly, the majority asserts that it is irrational for the state to regulate the full-time provider of abortions (those primarily performing abortions) more heavily than the occasional provider. While it may be true that the full-time abortionist may consider himself or herself "more skilled" and so theoretically need less regulation, the majority overlooks that a state with limited resources may rationally choose to direct its energies to improving the lot of the greatest number. For example, if the state, after the proper enactment of legislation, chooses to regulate ASTCs and reduce the risk of minor surgery (as well as its cost) for 100,000 of its citizens, and more instrusive regulation of occasional providers would help only 2,000, the state may very properly deal with the 100,000 first. Further, the cost of regulation per patient will be lower if the state concentrates its attention on high-volume businesses; surely this constitutes a rational relation to a permissible end.

The majority's treatment of the ASTCA and the IHFPA under the strict scrutiny test is just another way the majority circumvents and fails to effectuate the purpose of the ASTCA, i.e., to regulate changes in the provision of medical services. Essentially, the majority substitutes its judgment for that of the legislature; this is truly unfortunate in this case since courts should defer above all to a legislature's judgments on social and economic matters. *See Dandridge v. Williams*, 397 U.S. 471, 90 S.Ct. 1153 (1970). Lawyers who are now judges are neither trained nor experienced in the medical disciplines possibly related to abortion procedures, e.g., obstetrics, gynecology, psychiatry, pathology, general surgery, or emergency medicine. Nor are judges versed in the nuances of the prac-

tices and techniques of the medical profession and thus are ill-equipped to substitute their views regarding what is medically adequate, proper, or antiseptic. "As recently stated by the Supreme Court, 'there certainly is no reason to think judges are better qualified than appropriate professionals in making such decisions.' " *St. Mary of Nazareth v. Dep't of Health & Human Services*, 698 F.2d 1337, 1346 (7th Cir. 1983) (quoting *Youngberg v. Romeo*, 457 U.S. 307, 323, 102 S.Ct. 2452, 2462 (1982)). However, this majority decision is replete with such medical assertions. For example, the majority states, "The testimony regarding many of the physical plant requirements make clear that they have 'no medical justification whatsoever' when applied to first and early second trimester abortions of the type involved in this case." However, the ASTCA was intended to regulate *all minor surgical procedures*, and the legislature is free to enact reasonable legislation. Under these circumstances, and in light of the real risks that accompany minor surgical procedures, including abortions, it is dangerous for the majority to substitute its judgment as to what constitutes necessary and/or appropriate ASTC regulations. Although in *Dandridge* the Supreme Court was concerned with welfare assistance programs, the following admonition is as applicable today as it was then:

> "We do not decide today that the [Illinois] regulation is wise, that it best fulfills the relevant social and economic objectives that [Illinois] might ideally espouse, or that a more [reasonable] system could not be devised. Conflicting claims of morality and intelligence are raised by opponents and proponents of almost every measure, certainly including the one before us. *But the intractable economic, social and even philosophical problems presented by [regulating medical services] are not the business of this [c]ourt.* The Constitution may impose certain procedural safeguards upon [the regulatory] system . . . . *But the Constitution does not empower this [c]ourt to second-guess state officials charged with the difficult respon-*

> *sibility of [guaranteeing its citizens adequate, cost-effective but safe, medical services.]*"

Id. at 487, 90 S.Ct. at 1162-63 (citations omitted) (emphasis added). *See also In re U.S. ex rel. Missouri State High School, etc.*, 682 F.2d 147 (8th Cir. 1982) ("Once a rational relationship exists, and it exists here, judicial scrutiny must cease. Whether the rule is wise or creates undue individual hardship are policy decisions better left to legislative and administrative bodies").

Lastly, because the courts "have returned to the original constitutional proposition that courts do not substitute their social and economic beliefs for the judgment of legislative bodies," *Ferguson v. Skrupa*, 372 U.S. 276, 730, 83 S.Ct. 1028, 1031 (1963), the "abortion neutral" ASTCA is entitled to presumptive validity. It is a well-recognized principle that

> "The question, whether a law be void for its repugnancy to the constitution, is, at all times, a question of much delicacy, which ought seldom, if ever, to be decided in the affirmative, in a doubtful case. The court, when impelled by duty to render such a judgment, would be unworthy of its station, could it be unmindful of the solemn obligations which that station imposes. But it is not on slight implication and vague conjecture, that the legislature is to be pronounced to have transcended its powers, and its acts to be considered as void. *The opposition between the constitution and the law should be such that the judge feels a clear and strong conviction of their incompatibility with each other.*"

Fletcher v. Peck, 10 U.S. (6 Cranch) 85, 128 (1810) (emphasis added). " 'Every possible presumption . . . is in favor of the validity of a statute, and this continues until the contrary is shown beyond a rational doubt.' " *Powell v. Pennsylvania*, 127 U.S. 678, 684 (1887) (quoting *In re Sinking Fund Cases*, 99 U.S. 700, 718 (1879)). *See also Kelley v. Johnson*, 425 U.S. 238, 247, 96 S.Ct. 1440, 1445-46 (1976) (Justice Rehnquist, now Chief Justice, stated that

state decisions regarding social legislation are "entitled to the same sort of presumption of legislative validity as are state choices designed to promote other aims within the cognizance of the State's police power."). As the Supreme Court recently observed in *Pension Benefit Guaranty Corp. v. R.A. Gray & Co.*, 467 U.S. 717, 729, 104 S.Ct. 2709, 2717 (1984):

> " 'It is by now well established that legislative Acts adjusting the burdens and benefits of economic life come to the Court with a presumption of constitutionality, and that the burden is on one complaining of a due process violation to establish that the legislature has acted in an arbitrary and irrational way. *See, e.g., Ferguson v. Skrupa*, 372 U.S. 726, 83 S.Ct. 1028, 10 L.Ed.2d 93 (1963); *Williamson v. Lee Optical Co.*, 348 U.S. 483, 487-488, 75 S.Ct. 461, 464, 99 L.Ed. 563 (1955).' "

(quoting *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 15, 96 S.Ct. 2882, 2892 (1976)). *See also Rhinebarger v. Orr*, No. 87-1738, slip op. at 3 (7th Cir. February 4, 1988) (Chief Judge Bauer observed: "It is well established that congressional legislation 'adjusting the burdens and benefits of economic life' are presumed constitutional and that 'the burden is on one complaining of a due process violation to establish that the legislature has acted in an arbitrary and irrational way.' "). Here, the plaintiffs-appellees have not demonstrated that the Illinois legislature acted in an arbitrary or irrational way when enacting the ASTCA and the IHFPA. Thus, within the parameters of *Roe*, I am convinced that the state is free to regulate abortions to the same extent it regulates similar surgical procedures. I fail to understand how the majority holds otherwise since the Supreme Court has never held that *Roe* holds to the contrary. Thus, I would reverse the district court's order preliminarily enjoining the ASTCA and the IHFPA.

III

However, even if *Roe* and its progeny were to apply to the ASTCA and IHFPA as asserted by the majority, the Act would still be constitutionally valid. The holding of *Roe* and its progeny

> "does not mean that a state never may enact a regulation touching on the woman's abortion right during the first weeks of pregnancy. Certain regulations that have no significant impact on the woman's exercise of her right may be permissible where justified by important state objectives."

Akron, 462 U.S. at 430, 103 S.Ct. at 2492. The plaintiffs asserted that the ASTCA and IHFPA substantially burdened the woman's right to terminate her pregnancy in three ways: (1) by limiting the availability of abortions; (2) by increasing the cost of an abortion; and (3) by requiring the provider to fulfill the certificate of need requirements subjecting the abortionist to a "public veto of his [abortion] services." As I previously noted, § 16(1) of the MPA and its companion clause in ¶ 157-8.3(A) of the ASTCA could very well be considered unconstitutional and therefore should be enjoined. Thus, the licensure of facilities allegedly devoted primarily to the performance of abortions does not limit the availability of abortions since many other surgeons, if they so choose, could perform first-trimester abortions in their offices.[16] Thus, the ASTCA cannot be said to limit the availability of abortions. Further, the possibility that Ragsdale's clinic might possibly close does not significantly, if at all, affect the availability of abortions. The plaintiffs stated that "there are approximately 65,860 abortions performed in Illinois annually." *Ragsdale v. Turnock*, 625 F.Supp. 1212, 1219

[16] In *Akron* the Supreme Court reaffirmed its trimester approach. Thus, I am convinced that the state could constitutionally require that all second-trimester abortions be performed in an ASTC. Even the plaintiffs' experts testified that the risks of an abortion rise substantially in the second trimester.

(N.D. Ill. 1985). Of these, Ragsdale performs some 3,400 to 3,500 annually, or some 5 percent. Additionally, there are some 42 to 44 ASTCs in Illinois and "approximately half of these provide abortions services." *Id.* However, the district court found that Ragsdale was the only available abortionist in his area. The record reveals that Ragsdale initially testified that he was the "only provider" of abortions in his area. Subsequently, he qualified his testimony, stating he was "primarily, and, in many ways, the only abortion provider" in the area. However, Ragsdale concluded, stating: "To the best of my knowledge, no one else intends" to perform abortions in the area. These statements, contrary to the district court's finding that Ragsdale was the "only" abortion provider, do not establish that abortions would be unavailable in the area if Ragsdale had to close his facility (because he failed to lease or purchase a new facility). Inferring from the high volume of abortions performed at Ragsdale's clinic, it is apparent that the efficiency of the clinic had reached that of an "economy of scale," making it uneconomical for other physicians to enter the abortion market in the area. However, assuming *arguendo*, that abortionists receive anywhere from $250 to $400 per abortion,[17] it is unlikely that another operator (like Ragsdale) would not perform abortions in the area in the event Ragsdale's business closed. The physician-surgeon entrepreneur could not ignore Ragsdale's apparent potential annual gross income from abortions alone, approximately $875,000 ($250 per abortion x 3500 abortions per year). The district court's finding that the closing of Ragsdale's clinic would make abortions unavailable is mere speculation and clearly erroneous.

[17] Plaintiff's counsel stated during closing argument before the district court that the fee charged in a hospital for an abortion was $1,000 and that the hospital fee was 2.5 to 4 times greater than the cost of an abortion performed in an outpatient facility (including a physician's office). Thus, according to plaintiff's counsel, an outpatient abortion costs $250 to $400.

The district court found the second burden on a woman's right to terminate her pregnancy created by the ASTCA licensing requirement was that the licensing requirement raised the cost of an abortion "by $25 to $40 for abortions performed at Ragsdale's clinic." The defendants argue that the district court erroneously relied on hearsay for the basis of its factual findings regarding the increased cost. I couldn't agree more since the defendants objected throughout the hearing to the relevancy and admissibility of Ragsdale's alleged cost sheets. The alleged cost sheets consisted of Ragsdale's musings after allegedly discussing tentative plans to move his facility with contractors and other vendors. Ragsdale, a physician and surgeon, is no more an expert in cost accounting, contracting, architecture, etc., than the respective experts in these areas are knowledgeable about the problems and practice of surgery and/or medicine. Thus, just as the majority rejected the defendant's architectural expert's testimony regarding the medical "need for the ventilation requirements," so too should the majority, on proper balance, reject Ragsdale's compliance cost estimates.

On the other hand, assuming *arguendo*, that Ragsdale's cost-related testimony was properly received in evidence, I am convinced that the important state health objective of insuring safe, yet cost-effective, medical service by requiring minimum engineering and construction standards justified the *de minimis* financial impact that compliance with the regulations places on the cost of an abortion. The majority inaccurately asserts that "Dr. Ragsdale testified that he estimated compliance with the regulations would entail a per-patient cost of between $25 and $40." The record reveals that Dr. Ragsdale testified that he estimated the added costs of complying with the regulations *over and above the costs required simply to relocate his current practice in such a manner as he deemed appropriate for his needs*, as $25.21 per patient. (Ragsdale Tr. 400-01). This added cost of $25.21 certainly cannot be considered as significantly more than the $19.40 (less than a $5 difference) increase per abortion for tissue examina-

tion upheld by the Supreme Court in *Ashcroft* because "in light of the substantial benefits that a pathologist's examination can have, this small cost is clearly justified." 462 U.S. at 490, 103 S.Ct. at 2524. Moreover, it should be pointed out that the increased cost testified to herein, unlike the one in *Ashcroft*, would at best only be temporary and not one that would remain *ad infinitum*. Dr. Ragsdale admitted that "much of the debt would be retired after two to five years." Thus, after two years the fee increase would be reduced to $10.90 per patient, and after five years to a mere $3.40 per patient. I am convinced that the minimum engineering and construction design requirements allegedly at issue, which ensure only that all surgical procedures performed in ASTCs, including first-trimester abortions, are performed in clean, sanitary, and safe structures are a substantial benefit to the health and safety of patients, and the miniscule financial impact referred to is clearly *de minimis* and justified.

One last observation respecting the cost of an abortion. After searching the record, I found no evidence establishing the cost of an abortion performed in a doctor's office. However, the plaintiff's counsel during closing argument before the district court stated that the costs of an abortion performed in a hospital ($1,000) was 2.5 to 4 times as costly as that of one performed in a surgeon's office or in an outpatient clinic. These figures reflect that outpatient abortion costs, including those performed in a physician's office, range from $250 to $400 each. Thus, the $250 cost of an abortion performed in Ragsdale's ASTC, even if operating in full compliance with the Act, may in fact represent the low end of the abortion market price. This proposition supports my earlier observation that Ragsdale's clinic, because of its efficiency, dominated the local market. Further, assuming that Ragsdale's increased cost per abortion was $25.21, the percentage increase is in the range of 6 to 10 percent, certainly *de minimis*. It is not as if the price of an abortion went from $250 to $500, a significant burden.

This brings us to the third burden allegedly impinging upon a woman's qualified right to terminate her pregnancy, i.e., Certificate of Need (CON) for Ragsdale's ASTC and the related public hearing required pursuant to the IHFPA.[18] The majority unbelievably holds the certificate of need requirement unconstitutional for the reason, *inter alia*, that the public hearing accompanying a certificate of need created a public veto of a woman's qualified right to an abortion. The record establishes unequivocally that Ragsdale's landlord, a hospital, wished to terminate its lease with Ragsdale because Ragsdale failed to refer patients to the hospital. Ragsdale applied to the State of Illinois, pursuant to the ASTCA and IHFPA, for a license

[18] Pursuant to ¶¶ 1155-1160 of the IHFPA, and as noted by the majority, "anyone seeking to open an ASTC [must] obtain a certificate of need for the facility from the Department of Public Health after a public hearing and a 120-day review period." A CON is granted if the State Board finds

> "(1) that the applicant is fit, willing, and able to provide a proper standard of health care service for the community with particular regard to the qualification, background and character of the applicant, (2) *that economic feasibility is demonstrated in terms of effect on the existing and projected operating budget of the applicant and of the health care facility;* in terms of the applicant's ability to establish and operate such facility in accordance with licensure regulations promulgated under pertinent state laws; and in terms of the projected impact on the total health care expenditures in the facility and community, (3) that safeguards are provided which assure that the establishment, construction or modification of the health care facility is consistent with the public interest, and (4) *that the proposed establishment, construction or modification is consistent with the orderly and economic development of such facilities and is in accord with standards, criteria, or plans of need adopted and approved pursuant to the provisions of Section 12 of this Act* for such facilities for comprehensive health care in the community, area, or State served by such facilities."

111½ Ill. Rev. Stat. ¶ 1156 (emphasis added). In this manner the state has attempted to reduce skyrocketing health care costs by limiting the expansion of unnecessary medical facilities.

for his new facility. After a full investigation and subsequent to holding public hearings, the state agency found that there was *in fact a need for Ragsdale's medical services.* At the public hearing a number of citizens protested against abortions stating their pro-life positions. It stretches the imagination that one would write that the exercise of one's First Amendment rights to object to an issue be treated somehow as creating a burden on a woman's right to an abortion. The majority, however, asserts that "the state's unwillingness or inability to confine the proceedings [the public hearings on Ragsdale's CON for his ASTC] to its even arguably legitimate goals bolster our conclusion [that the CON] requirement cannot stand." This statement flies in the face of the fact that the state after due and considerate deliberations absent emotion or hysteria objectively analyzed and in fact found that need existed for Ragsdale's medical services. Although I have previously expressed that an individual, including an abortionist, should be free from picketing in front of his private home, *see Schultz v. Frisby*, 807 F.2d 1339, 1355 (7th Cir. 1986) (Coffey, J., dissenting), *reh'g granted and decision vacated*, 818 F.2d 1284 (7th Cir. 1987), *aff'd by equally divided vote* 619 F. Supp. 792, 822 F.2d 642 (7th Cir. 1987), *cert. granted*, 1988 U.S. L.W. 2211 (January 11, 1988), public hearings are a different matter. Public hearings are an open forum where *all citizens* should have the right to be heard in an organized manner in our democratic form of government. That some open forums or demonstrations sometimes "degenerate into a shouting match" is nothing new to our right of free speech, much less to our national system of justice and ordered liberty. I fail to comprehend the majority's contrary view.

Further, the record in this case establishes that the ASTCA regulations in question place *no burden whatsoever* on a woman's decision to terminate her pregnancy in the first trimester because they reflect nothing but the common, accepted, and approved standards of medical practice and procedure as testified to by the medical experts. For example, § 205.240 of the ASTC regulations

requires the management or owner of an ASTC to formulate written policies and a procedures manual. Dr. Ragsdale described this requirement as standard medical and administrative practice. Other administrative and organizational regulations, such as those requiring written safety plans (§ 205.510), appointment of a qualified consulting committee and medical director (§ 205.230), and written personnel policies (§ 205.310), as well as those requiring sanitary conditions (§ 205.420) and proper disposal of all materials from the abortion procedure and maintenance of the equipment in good working order (§ 205.410) are merely enunciations of universally recognized standard practice for performing surgical procedures in an outpatient facility. As Dr. Ragsdale conceded on direct examination, most of the regulations of this type simply "stated the obvious" and in no way impinged upon a woman's decision, much less her right, to an abortion. Moreover, the building design and construction requirements contained in the ASTC regulations reflect proper engineering design and practice from a medical service point of view and accepted minimum standards for medical facilities. Examples include requirements for testing and balancing heating, ventilation, and air conditioning systems to ensure that they are in proper working condition (§ 205.1510), insulation in appropriate locations (§ 205.1520), and a minimum ceiling height of eight feet with appropriate exceptions for certain rooms, such as storage rooms (§ 205.1400). I believe that the state has more than just a compelling interest, and in fact has an overriding interest, in ensuring that any and all ASTCs performing any surgical procedures, including first-trimester abortions, are designed and constructed to meet basic engineering standards for medical facilities in order that all fairly sophisticated medical procedures are conducted "under conditions ensuring the maximum safety" of the patient. *Connecticut v. Menillo*, 423 U.S. at 11, 96 S.Ct. at 171.

Dr. Hern, the plaintiff's alleged expert witness at trial, testified that "90 to 95 percent . . . of all first-trimester procedures in this country . . . are performed by vacuum

aspiration technique of some kind," and are "the safest surgical procedure[s] now performed." The record also established that other abortion procedures, such as the saline, urea, and installation techniques (involving inserting a needle into the amniotic cavity, withdrawing fluid, and installing a saline solution within the amniotic cavity) were also being performed in ASTCs. These abortion procedures have a higher complication and fatality rate than other abortion procedures, such as the vacuum aspiration and dilation and evacuation methods. Since more complicated and involved abortion procedures which require close supervision, control and regulation are also performed in ASTCs, I am persuaded that the state can, should, and must regulate its ASTCs in order that it might protect its citizens from possible serious medical problems which could very easily arise. The State of Illinois, through its legislators, has the authority, if it so determines, to require a higher standard for the operation of these clinics, including attending and supervising personnel, building specifications and design, as well as maintenance, in order that it might protect its citizens, just as the State of Wisconsin has the authority to require higher standards for its prisons and the State of Georgia to protect its inmates if it so wishes. *Cf.* Wis. Administrative Code §§ HHS 302, *et seq.* with Georgia Code Annotated § 42-5-50, *et seq.* Similarly, the State of Illinois can pass legislation mandating more all-inclusive immunization requirements for school-age children than those required by the State of Missouri. *Cf.* Illinois Revised Statute Chapter 111.5, ¶ 22.11 and Illinois Administrative Code Tit. 77, § 696.10 with Missouri Revised Statute § 167.181.

The Illinois legislature has determined that the ASTCA and the IHFPA, by their very enactment, are very important social and economic laws for the betterment and protection of its citizens. Neither the ASTCA nor the IHFPA burden a woman's qualified right to terminate a pregnancy, and both Acts further serve the state's important interest in the health and welfare of its citizens;

thus, even under *Roe* and its progeny the ASTCA and IHFPA must be held constitutional.

Finally, turning to those abortion-specific ASTCA regulations; I would hold that all but one of these abortion-specific regulations survive *Roe*'s scrutiny. Initially, I would hold that ¶ 157-8.6-1[19] properly requires a physician actively engaged in practice at an ASTC be on the board of directors of any ASTC "devoted primarily to providing facilities for abortions" as a condition of licensure. Since the Supreme Court's decision in *Connecticut v. Menillo*, it has been clear that states can require that only physicians perform abortions. Illinois' additional requirement that a practicing physician/surgeon be on the board of an ASTC primarily involved in providing abortion services simply guarantees that a physician be involved in the business decisions of the board of directors (exclusive of the patient-doctor abortion decision) and thus ensure safe medical procedures and practices. Further, Dr. Ragsdale testified that ¶ 157-8.6-1 did not burden the woman's right to an abortion. Additionally, Margaret Moe, who desired to offer abortions out of her clinic, is now free (in light of the probable unconstitutionality of § 16(1) of the MPA and its companion clause in the ASTC definition) to do so as long as the clinic is not devoted primarily to surgical procedures. If Moe chooses to incorporate her clinic as an ASTC, she, without any trouble, will be able to retain a surgeon performing abortions at her clinic to serve on her ASTC board of directors. This requirement neither limits the availability nor increases the cost of an

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[19] Paragraph 157-8.6-1 provides:

"Abortions—Licensed physicians

§ 6.1 Notwithstanding any other provision of this Act, any corporation operating an Ambulatory Surgical Treatment Center devoted primarily to providing facilities for abortion must have a physician, who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the Center, on the board of directors as a condition to licensure of the Center."

abortion performed at an ASTC and in fact serves the important state interest in protecting the health of its citizens. Thus, ¶ 157-8.6-1 is constitutional.

Further, the record reveals that those regulations addressing operative care do not burden a woman's right to an abortion. Section 205.530(c) of the ASTC regulations requires that all tissues removed during surgery be examined by a qualified consulting pathologist. The Supreme Court upheld an almost identical regulation in *Ashcroft*. The Court held that a Missouri regulation requiring all tissues surgically removed (including tissue removed during first-trimester abortions) be examined by a pathologist "reasonably related to generally accepted medical standards and 'further[s] important health-related state concerns.'" 462 U.S. at 487, 103 S.Ct. at 2523 (quoting *City of Akron*, 462 U.S. at 430). The Court stated: "As a rule, it is accepted medical practice to submit *all* tissue to the examination of a pathologist. This is particularly important following abortion, because questions remain as to the long-range complications and their effect on subsequent pregnancies." 462 U.S. at 487-88, 103 S.Ct. at 2523 (emphasis in original). Further, the information and knowledge gained from the aggregated pathological testing and reports will aid other women in the future. The requirement for a pathological report on any abnormalities in the tissue in question is proper and constitutional in light of *Ashcroft*.

Section 205.760 of the ASTC regulations requires a report, on forms provided by the Department of Public Health, of each abortion procedure performed in an ASTC within ten days following the month in which the abortion was performed. If the doctor who performed the abortion later discovers a complication, such as hemorrhaging, then he or she is required to file a supplemental report.[20] In *Planned Parenthood v. Danforth*, 428 U.S. 52, 96 S.Ct. at 2831 (1975), the Supreme Court stated:

[20] In a companion regulation which is not abortion specific, § 205.620 requires each ASTC to submit annual statistical data to the De-

(Footnote continued on following page)

> "Recordkeeping and reporting requirements that are reasonably directed to the preservation of maternal health and that properly respect a patient's confidentiality and privacy are permissible. . . . Recordkeeping of this kind, if not abused or overdone, can be useful to the state's interest in protecting the health of its female citizens, and may be a resource that is relevant to decisions involving medical experience and judgment. . . . As so regarded, we see no legally significant impact or consequence on the abortion decision."

Id. at 80-81, 96 S.Ct. at 2846 (footnote omitted). Further, Dr. Hern, one of the plaintiffs' alleged experts, testified specifically that the reporting of statistics "is essential to public health evaluation." Thus, the reporting requirements at issue are consistent with the Court's holding in *Danforth* and are constitutional.

Other abortion-specific regulations require a determination of blood RH factor prior to performance of an obstetrical procedure, including an abortion (§ 205.730(a)(1)) and hemoglobin and hematocrit and urine analysis examinations before performing an abortion, as well as procedures performed with general anesthesia or local anesthesia with sedation (§ 205.520(b)). At trial, Dr. Ragsdale admitted that he had no disagreement with the need to perform appropriate laboratory tests. Thus, these provisions in no way impinge upon a woman's decision to have an abortion because they merely state the standard medical tests necessary to perform a safe abortion. In this respect, they are no more offensive or intrusive on a woman's right to an abortion than § 205.710 which states: "Abortions shall be provided to the public with the same

[20] *continued*
partment of Public Health. This data is to include the number and type of procedures performed and complications reported, the number of patients requiring transfer to a hospital due to complications, the number of patients returning for followup contact, and the number of deaths.

standards of safety, effectiveness, and regard for patients['] rights as any other health service." As Dr. Ragsdale's counsel concededly stated at trial, "Obviously, Dr. Ragsdale agrees with that statement. We agree with that, and I suspect everyone in this room agrees with that statement."

Finally, I do not agree with the majority's conclusion that the counseling requirements of § 205.730(b) run afoul of the Supreme Court's ruling in *Thornburgh v. American College of Obstetricians*, 476 U.S. 747, 106 S.Ct. 2169 (1986). In *Thornburgh* the Court found unconstitutional provisions of the state statute that required a woman to be informed of fetal characteristics, the availability of financial assistance, detrimental physical and psychological effects, and all particular medical risks. *Id.* at 759-765, 106 S.Ct. at 2178-81. But the Court held that this detailed information exceeded the state's interest in describing the general subject matter relevant to informed consent because it "is not medical information that is always relevant to the woman's decision and it may serve only to confuse and punish her and to heighten her anxiety contrary to accepted medical practice." *Id.* at 762, 106 S.Ct. at 2179.

In contrast, the counseling requirements of § 205.730(b) include a description of the procedure to be performed, an explanation of risks and possible complications, and a discussion of alternatives. These requirements are significantly less instrusive than the ones invalidated in *Thornburgh*, and the record establishes through Dr. Hern's testimony as an expert witness, that counseling is an indispensable part of a thorough pre-operative evaluation and preparation of a patient for an abortion procedure. Dr. Hern testified that appropriate counseling should include a discussion of the alternatives for dealing with pregnancy.[21] As the Supreme Court has repeatedly recognized,

[21] Dr. Hern, the court-qualified expert, testified as follows:

"Q Now, you testified earlier that you do provide counseling in your facility, is that right, doctor?

(Footnote continued on following page)

"The decision to abort . . . is an important, and often stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences." *Danforth*, 428 U.S. at 67, 96 S.Ct. at 2840. *See also City of Akron*, 462 U.S. at 442-43, 103 S.Ct. at 2499.[22] This is

[21] *continued*

A Yes.

Q . . . well, why do you provide [counseling], Dr. Hern?

A Well, I believe that it is important for each patient to have not only a good understanding of the procedure that she is going to be having *and how she got pregnant* [?!] and what the methods are for her, I mean, for her to be permitted or to permit her to avoid unwanted pregnancies in the future.

Q Well, do you say the same things to every patient, Dr. Hern? Do you give the same counseling?

A In general, yes. Although it really depends upon the individual patient as to how much we give as to that but I also think that—how much emphasis *we give* and as to what, but, as I say, it is also important for the patient to have an opportunity to express her feelings about the pregnancy and about the abortion and, perhaps, the relationship in which it occurred.

Q *Would you always*, Dr. Hern, for example, *include in your discussion with the woman a discussion of the alternatives for dealing with pregnancy*?

A *Yes.* And depending also to some extent on the patient's interest in this subject. *Some patients absolutely refuse to discuss alternatives; they come in and they have their minds absolutely made up about what they want to do and they are impatient to get on with the process and they really do not wish to spend a great deal of time talking about, for example, adoption.*"

(Emphasis added).

[22] According to the majority, the counseling requirement and in particular "the requirement of a 'discussion of alternatives' is unconstitutional." The majority relied on Ragsdale's testimony to the effect that discussions of *alternatives* might not be appropriate. Ragsdale speculated that it would be inappropriate to inform a woman of alternatives if her continuing health was dependent on

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true since "[a]bortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of potential life." *Harris v. McRae*, 448 U.S. 297, 325, 100 S.Ct. 2671, 2692 (1980). Thus, I emphasized in *Zbaraz v. Hartigan*, 763 F.2d at 1549-50 (Coffey, J., dissenting):

> "There are severe psychological and emotional stresses involved not only before and during the abortion procedure, but for days, months and even years following the procedure . . . . For many individuals . . . the abortion decision raises questions that are often influenced by sincere, deep-rooted religious beliefs, moral principles, and convictions. . . . [J]ust as in any surgical procedure, [a woman] is entitled to an explanation of the reasonable alternatives to abortion. . . ."

I am firmly convinced that Illinois can require a counselor to provide a woman with a description of the procedure to be performed, an explanation of risks and possible complications, and a discussion of alternatives so that the woman can make a *responsible enlightened choice* in light of the fact that no other medical procedure "involves the purposeful termination of a potential life." *Harris v. McRae*, 448 U.S. at 325, 100 S.Ct. at 2692. Further, the majority's rejection of the counseling requirements ignores the recent trend in medicine which encourages patients to seek second opinions before undergoing surgical procedures. In some instances insurance companies have even required a second opinion with respect to non-emergency surgeries before providing coverage. These developments reflect the importance the medical profession (as well as those footing

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[22] *continued*

her undergoing a medically necessary abortion. Obviously, in this situation a "discussion of alternatives" is inappropriate simply because there are no *alternatives*. The majority's interpretation of the Illinois regulations would lead to absurd results. It is clear that a discussion of alternatives is required *only* when alternatives in fact exist.

the bill) places on informed consent. The Illinois counseling regulations merely require that a woman planning to terminate her pregnancy do so knowingly; *Roe* does not hold to the contrary. However, § 205.730(b)(2)(D) requires that "[c]ounselors shall have no financial interest in the patient's decision" and appears to interfere with the physician-patient relationship and should be severed and enjoined. Thus, I do not believe that the counseling requirements of § 205.730(b), except (2)(D), are improper and would uphold their validity.

IV

In conclusion, I am convinced that individual states have the obligation, the duty, and the power to license medical ASTC facilities where semi-complex (minor) surgical procedures, including first-trimester abortions, are performed as a valid exercise of a state's interest in protecting health and ensuring maximum safety for the patients. Determining where to strike the balance between competing interests is a matter for the legislature, not for the court. The Constitution wisely vests the legislative branch of the government with the power and authority to enact laws, for the legislature is better equipped to carry out that task in that interested parties, such as state and local governmental representatives, medical experts, etc., are able to present their respective positions before the legislative body in a more open, unrestricted, informal forum. Thereafter, the myriad of questions and problems, as well as their possible solutions, are brought before the entire legislative branch of government and are subject to the scrutiny of public hearing and debate. When dealing with the complex and ever-changing question of how to provide the best health care at a reasonable cost to its citizens, the factfinding and policy making capabilities of a court of law are far more limited and confined due to the very nature of a court of law. A truly independent judiciary must always exercise its powers of review and decision making with discretion and reservation, recognizing that we are not competent to make social and economic

policy decisions, and giving due deference to the legislative branch of government. Our judicial responsibility obligates us to declare an act by another governmental unit to be void only if we believe the enacted law is contrary to the Constitution. After reviewing the ASTCA and the challenged provisions of the IHFPA, I am convinced that the expressed will of the people as enacted in these Illinois statutes is not contrary to the principles of the Constitution; thus, I would not interfere with this well-reasoned judgment of the Illinois legislature, a coequal branch of the government. Surely the Illinois legislature is entitled to require that all surgical procedures, including first-trimester abortions, are performed "under conditions ensuring maximum safety for the woman [as well as the man]." *Connecticut v. Menillo*, 423 U.S. at 11, 96 S.Ct. at 171.

Moreover, other than § 16(1) of the MPA, its companion clause in the ASTCA, and § 205.730(b)(2)(D), I believe that the statutes and regulations in question do not place a burden on a woman's decision to terminate her pregnancy in the first trimester. Further, if one is able to find a burden, it is certainly below the level of *de minimis*. Lastly, the regulations reflect common, accepted and approved standards of medical practice and procedure and are designed to enhance the safety of Illinois' citizens, an important state interest. For the foregoing reasons, I would reverse the order of the district court.

APPENDIX

TITLE 77 ILLINOIS ADMINISTRATIVE CODE: PUBLIC HEALTH

CHAPTER 1: DEPARTMENT OF PUBLIC HEALTH

SUBCHAPTER b: HOSPITALS AND AMBULATORY CARE FACILITIES

PART 205
MINIMUM STANDARDS, RULES AND REGULATIONS FOR THE LICENSURE OF AMBULATORY SURGICAL TREATMENT CENTERS.

SUBPART A: GENERAL

Section 205.120 Licensure

a) An application for license shall be made to the Department on forms provided by it. This application shall contain the information required under the Act and this Part. The application shall be submitted not less than sixty (60) days prior to the date of intended operation.

b) The application shall include but not be limited to the following information:

1) the name(s) and address(es) of person(s) who own and/or operate the facility and the name under which they do business. A corporation shall submit:
   A) a copy of its certificate of incorporation,
   B) list of the title, name, and address of each of its corporate officers,
   C) list of the name and address of each of its shareholders holding more than 5%, of the shares.
2) location of the facility.
3) description of the facility including but not limited to interviewing, examination, surgical, and recovery room facilities.

4) schematic architectural plans.
5) documentation of compliance with all applicable building, utility and Safety Codes.
6) description of services to be provided by the facility including a list of surgical procedures to be performed.
7) list of all personnel including their name, address, position, qualifications and licensure.
8) All applications shall be signed by the applicant and the application shall include a verification form acknowledging the application to be true and complete and certifying that the applicant has knowledge of and understands the action required to comply with the Act and licensing requirements. The form shall be verified by a notary public. The forms shall be accompanied by a license fee of $500.
9) As a condition of the issuance or renewal of the license of any Ambulatory Surgical Treatment Center:
   A) The applicant shall file a statement of ownership. The applicant shall agree to update the information required in the statement of ownership every 6 months from the initial date of filing,
   B) Each license shall file an attested financial statement with the Department by July 1, 1980 and at times thereafter as required,
   C) Financial statements shall be filed annually on or before April 1, of each year for the previous calendar year, or within three (3) months after the close of the fiscal period of the licensee,
   D) A financial statement shall be filed with the Department on forms provided by the Department or on annual financial statements prepared on forms used by the applicant. At minimum, they shall include detailed balance sheets, statements of income and statements of expense,

   E) Every facility licensed under this Act, and any premises proposed to be conducted as a facility by an applicant for a license shall be open during its regular business hours to an inspection authorized in writing by the Director. No notice need be given to any person prior to any inspection,
   F) Any corporation operating an Ambulatory Surgical Treatment Center devoted primarily to providing facilities for abortion must have a physician who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the center, on the Board of Directors as a condition to licensure of the center.

c) Only those facilities, services, programs and procedures included in the application shall be licensed. A new application is required for the following:
   1) change in ownership,
   2) change in location,
   3) remodeling of facility so as to change the interviewing, examination, surgical or recovery room space or number,
   4) addition of services or programs.

      AGENCY NOTE: The addition of new specialty services, for example, podiatry or obstetrics/gynecology, may require changes in consulting committee, procedures and/or staffing. Therefore, the Department finds that a new license is needed.

d) The license shall be valid for one (1) year, unless sooner suspended or revoked, shall be renewable annually upon approval by the Department and payment of a license fee of $300. Each license shall be issued only for the premises and persons named in the application and shall not be transferable or assignable. The licenses shall be posted in a conspicuous place on the licensed premises. A placard or registry of all physicians on staff in the facility shall be centrally located and available for inspection to

any interested persons. The renewal application shall be on forms provided by the Department and shall be submitted to it not less than 30 days prior to the expiration date.

e) The facility shall give written notice to the Department within seven (7) days of any of the following:
   1) change of administrative staff,
   2) change of medical director,
   3) change of staff physicians,
   4) change of supervising nurse,
   5) addition or deletion of surgical procedures performed,
   6) in the case of a corporation change in any shareholders equity involving 5% or more interest.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

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SUBPART D: EQUIPMENT, SUPPLIES, AND FACILITY MAINTENANCE

Section 205.410 Equipment

Equipment shall be in good working order and shall be available in numbers sufficient to provide good patient care based on the procedures to be performed in the facility.

a) There shall be monitoring equipment, suction apparatus, oxygen and related items available within the surgical and postoperative recovery area. Cardiac pulmonary resuscitation equipment shall be available in all facilities.

b) There shall be written procedures governing the care, use, sterilization, storage and disposal of all materials to insure that an adequate supply of sterile equipment is available for each procedure. The section on "Sterilization and Disinfection" from Infection Control in the Hospital, most recent edition, American Hospital Association, shall be used as the guideline.

c) There shall be written procedures to assure safety in storage and use of inhalation anesthetics and

medical gases. The current edition of the National Fire Protection Association Code (Standard No. 56a) shall be used as the standard.

d) There shall be written procedures to assure the safety in storage and use of all narcotics and medications in accordance with state and federal law.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

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SUBPART E: GENERAL PATIENT CARE

Section 205.520 Preoperative Care

a) Where medical evaluation, examination, and referral are made from a private physician's office, hospital, or clinic, pertinent records thereof shall be available and made part of the patient's clinical record at the time the patient is registered and admitted to the ambulatory surgical treatment center.

b) A complete medical history shall be obtained and the physical examination shall be complete. A hemoglobin or hematocrit and examination of the urine for sugar, protein, and acetone shall be performed by a qualified laboratory technician prior to the following procedures:
   1) those performed with general anesthesia,
   2) those performed with local anesthesia with sedation,
   3) those performed to terminate pregnancy.

c) A written statement indicating informed consent and a signed authorization by the patient for the performance of the specific surgical procedure shall be procured and made part of the patient's clinical record.

d) Surgical procedures shall not be performed on patient's having medical, surgical, or psychiatric conditions or complications as specified by the consulting committee in the facility's written policies.

(Source: Amended at 6 Ill. Reg. 10974, effective August 30, 1982)

Section 205.530 Operative Care

a) Surgical procedures shall be performed only by a qualified physician, dentist or podiatrist within the limits of his/her defined specific practice privileges.

b) A qualified anesthesiologist, a dental anesthesiologist or a certified registered nurse anesthetist, medically directed by a licensed physician who administers or directs the administration of anesthesia in an Illinois licensed hospital, shall be present for the administration of anesthetics and recovery of patients when any general or major regional anesthetic is used.

c) All tissues removed during surgery shall be examined by a consulting pathologist and all x-rays shall be read by a consulting radiologist who shall provide a written report of his/her examination to the attending physician. A copy of this report shall be filed in the patient's clinical record within seven (7) days.

(Source: Amended at 6 Ill. Reg. 13337, effective October 20, 1982)

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SUBPART G: ADDITIONAL REQUIREMENTS FOR FACILITIES IN WHICH OBSTETRICAL/GYNECOLOGICAL PROCEDURES ARE PERFORMED.

Section 205.710 Abortions

Abortions shall be provided to the public with the same standards of safety, effectiveness, and regard for patients rights as any other health service.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.720 Personnel

At least one registered professional nurse with postgraduate education or experience in obstetrical or gynecological nursing shall supervise and direct the nursing personnel and care of patients having obstetrical procedures.

AGENCY NOTE: Procedures involving the pregnant uterus are subject to particular complications and postoperative care requires a special knowledge on the part of nursing staff.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.730 General Patient Care

a) Examination

1) Prior to obstetrical procedures blood Rh factor shall be determined by a qualified laboratory technician for every patient.

2) The physician performing an abortion procedure shall establish the diagnosis of pregnancy by appropriate clinical evaluation and testing prior to performing an abortion procedure.

3) Time shall be allowed between the initial examination and termination of pregnancy to permit the reporting to and reviewing of all laboratory tests with the patient by the facility physician.

b) Counseling

1) Counseling shall be provided following disclosure to the patient of the diagnosis of pregnancy, and prior to performance of any surgical procedure. It shall be done individually and in a room designated for such use which shall not be the procedure room.

2) All facilities shall provide orientation training for counselors and insure that each counselor is qualified to:

A) Counseling shall be done by a person qualified to:

i) discuss alternatives for dealing with an unwanted pregnancy;

ii) describe the procedures used in the facility;

iii) explain the risks and possible complications of each procedure;

iv) provide contraception information.

B) Demonstration of such counseling qualifications shall be required by the Department.
C) Documentation of orientation training shall be required by the Department.
D) Counselors shall have no financial interest in the patient's decision.

3) Counseling shall include a discussion of alternatives, description of the procedure to be performed, explanation of risks and possible complications. Contraceptive information may be provided postoperatively. Group counseling may be provided in addition to individual counseling. The patient's clinical record shall include documentation of the counseling received.

AGENCY NOTE: In the opinion of the Ambulatory Surgical Treatment Center Licensing Board, the patient should make a decision concerning the procedure in an atmosphere free from coercion. Consequently, the Board believes this is best accomplished in a room separate and apart from the procedure room. The Board believes that it is difficult to reach a truly voluntary decision while the patient is undressed and on the procedure table.

(Source: Amended at 5 Ill. Reg. 12756, effective November 4, 1981)

Section 205.740 Preoperative Requirements

Abortions may be performed in a ambulatory surgical treatment center on only those patients with gestation up to and including 12 weeks commencing with ovulation rather than computed on the basis of the menstrual cycle, as determined by the physician, if the patient's medical condition permits. Abortions shall not be performed in an Ambulatory Surgical Treatment Center on those patients whose gestation exceeds 12 weeks.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.750 Postoperative Requirements

a) Each obstetrical/gynecological service shall provide Rh factor sensitization prophylaxis to all Rh negative patients according to standard medical procedures.
b) Information on availability of family planning services shall be provided, when desired by the patient. When, in the physician's opinion, it is in the best interest of the patient and with the patient's consent, family planning services may be initiated prior to the discharge of the patient.

(Source: Amended at 5 Ill. Reg. 12756, effective November 4, 1981)

Section 205.760 Reports

a) A report of each abortion procedure performed in an ambulatory surgical treatment center shall be made to the Department on forms provided by it. These reports shall be submitted not later than ten (10) days following the month in which the abortion was performed. Reports shall be submitted on procedures performed whether or not the patient was pregnant.
b) Reports shall not be filled out in such a manner or at such a time as to avoid accurate reporting of complications.
c) If the facility becomes aware of a complication following the submission of the original report, then a supplemental report shall be submitted to the Department.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

* * *

SUBPART I: BUILDING DESIGN, CONSTRUCTION STANDARDS, AND PHYSICAL REQUIREMENTS

Section 205.1320 General Considerations

a) Location

This facility shall be indentifiably separate from other facilities and functions.

b) Narrative Program
The sponsor for each project shall provide a narrative program of functions for the facility which contains space requirements, staffing patterns, departmental relationships and other basic information relating to the fulfillment of the institution's objectives. This may be a general or detailed description of each function to be performed, space needed for these functions, hours of operation, number of staff or other occupants of the various spaces, types of equipment required, interrelationship of various functions and spaces, and description of those services necessary for the complete functioning of the facility but which are available elsewhere in the community and, therefore, need not be duplicated in this facility. Explain the type of surgery or procedures, the volume of work, the number of doctors, etc.

c) Size
The extent (number and types) of the diagnostic, clinical, and administrative facilities to be provided shall be determined by the services contemplated and the estimated patient load as described in the narrative program.

d) Provisions for the Handicapped
The design shall provide for accessibility to the physically handicapped (public, staff, and patients).

e) Privacy for Patient
The design of the facility shall provide for the privacy and dignity of the patient during interview, examination, and treatment.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

* * *

Section 205.1360 Clinical Facilities

a) Examination room(s)

1) Each examination room(s) shall have a minimum clear floor area of 80 square feet, and a minimum dimension of 8 feet, excluding such spaces as vestibule, toilet, closet, and work counter (whether fixed or movable). Arrangements shall

permit at least 2'-6" clearance at each side and at both ends of the examination table.

2) A lavatory or sink equipped for handwashing with knee or foot control shall be provided.

3) A counter or shelf space for writing shall be provided.

b) Procedure room(s)

1) Provide at least one procedure room with a minimum clear area of 250 square feet and a minimum dimension of 14 feet, exclusive of fixed and movable cabinets and shelves. Any other procedure rooms shall not be less than 120 square feet with a minimum dimension of 10 feet.

2) Provide a communication system connecting with the control station.

3) Provide special features such as x-ray film illuminators, and storage space as required by the program.

c) Recovery room(s)

1) Room(s) for post-anesthesia recovery for surgical patients shall be provided.

2) Recovery room(s) shall contain a minimum of 100 square feet of usable floor space for single bed occupancy and at least 80 square feet per bed for multiple bed occupancy, so arranged that there will be at least 3 feet between beds and 4 feet of clear space at the foot of each bed.

3) This room(s) shall contain a drug distribution station, handwashing facility, charting facilities, nurses' station, and storage space for supplies and equipment.

4) Provide a toilet which is accessible to the recovery room, without having to leave the recovery room to reach it. The water closet shall be equipped with a gray diverter valve.

5) A separate supervised room may be provided for use by patients who are able to leave the recovery (post-anesthesia) room but need addi-

tional time for all vital signs to be stabilized to the point where the patient may leave the facility. This room shall be equipped with reclining or lounge type chairs for patients and shall contain a minimum of 50 square feet of usable floor space for each patient to be accommodated at any one time.

6) These recovery rooms may be combined, if desired.

7) Provide a minimum of four recovery beds or lounge chairs for each procedure room. At least one of the four must be a bed, and the other three may be lounge chairs or beds.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1370 Support Service Areas

a) A control station shall be located to permit visual surveillance of all traffic which enters the operating suite.

b) Provide sterilizing facility(ies) with high speed autoclave(s) conveniently located to serve all procedure rooms. Approved alternate provisions may be made for replacement of sterile instruments during surgery.

c) A drug distribution station shall be provided for storage and preparation of medication to be administered to patients.

d) Scrub stations with knee or foot or elbow actuated faucets shall be provided near the entrances to the procedure rooms. Scrub facilities shall be arranged to minimize splatter on nearby personnel or supply carts.

e) A soiled workroom for the exclusive use of the surgical suite staff shall be provided. The soiled workroom shall contain a work counter, sink equipped for handwashing, waste receptacle, and linen receptacle. This room may be used for cleaning anesthesia equipment.

f) Fluid waste disposal facilities shall be conveniently located with respect to the general procedure rooms.

g)

1) A clean workroom or a clean supply room is required when clean materials are assembled within the surgical suite prior to use. A clean workroom shall contain a work counter, sink equipped for handwashing, and space for clean and sterile supplies. A clean supply room shall be provided when the narrative program defines a system for the storage and distribution of clean and sterile supplies which would not require the use of a clean workroom.

2) An autoclave shall be incorporated into the clean workroom.

h) Anesthesia storage facilities shall be provided. Flammable anesthetics are prohibited.

i) Medical gas supply storage with space for reserve nitrous oxide and oxygen cylinders shall be provided, with all tanks properly secured.

j) Storage area for equipment and supplies used in surgical suite shall be provided.

k) Staff and personnel facilities shall be provided for male and female personnel (orderlies, technicians, nurses, and doctors) working within the surgical suite. The areas shall contain lounge, lockers, toilets, lavatories equipped for handwashing, and space for changing clothing. These areas shall be arranged to provide a one-way traffic pattern so that personnel entering from outside the surgical suite can change, gown, and move directly into the surgical suite. Space for removal of scrub suits and foot covers shall be designed so that personnel using it will avoid physical contact with clean personnel.

l) Provide change areas where patients can change from street clothing into hospital gowns in privacy, and be prepared for surgery. This shall include lockers, toilets, clothing change or gowning area(s), and space for the administration of medications.

m) Stretcher storage area shall be out of direct line of traffic.

n) Janitor's closet containing a floor receptor or service sink, and storage space for housekeeping supplies and equipment shall be provided exclusively for the surgical suite.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1380 Diagnostic Facilities

If the pre-admission evaluation tests are to be performed within the facility, the following services shall be provided.

a) Radiographic suite, if provided, shall contain the following:
   1) film processing area
   2) viewing and administration area
   3) film storage facilities
   4) toilet room with handwashing facilities, directly accessible from each fluoroscopy room without entering the general corridor area.
   5) dressing area with convenient access to toilets.

b) Laboratory suite shall contain the following minimum facilities:
   1) Laboratory work counter with sink and vacuum, and electric services.
   2) Lavatory or counter sink equipped for handwashing.
   3) Storage cabinet or closet.
   4) Specimen collection facilities equipped with a toilet and lavatory.
   5) Blood collection facilities shall have space for a chair and work counter.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

* * *

Section 205.1400 Details and Finishes

a) Minimum public corridor width shall be 5'-0", except those corridors where patients are transported in stretchers or carts shall be 8'-0".

b) The facility or section shall have at least two exits remote from each other. Other details relating to exits and fire safety shall be in accordance with Section 13 (Business Occupancy) of the latest edition of NFPA Standard 101 and the requirements outlined herein. These Standards govern where different from the code.

c) Items such as drinking fountains, telephone booths, vending machines, and portable equipment shall be located so as not to restrict corridor traffic or reduce the corridor width below the required minimum.

d) All doors to toilets which may be used by patients shall be equipped with hardware which will permit access in an emergency.

e) The minimum width of doors for patient access to examination and treatment rooms shall be 3'-0".

f) The minimum width of doors to rooms needing access for stretchers (procedure rooms, recovery) shall be 3'-8".

g) Doors on all openings between corridors and rooms or spaces subject to occupancy, except elevator doors, shall be swing type.

h) Doors, except doors to spaces such as small closets which are not subject to occupancy, shall not swing into corridors in a manner that might obstruct traffic flow or reduce the required corridor width.

i) Doors, sidelights, borrowed lights, and windows in which the glazing extends downs to within 18 inches of the floor (thereby creating possibility of accidental breakage by pedestrian traffic) shall be glazed with safety glass, wire glass, or plastic glazing material that will resist breaking and will not create dangerous cutting edges when broken in accordance with the State of Illinois Safety Glazing Materials Act (Ill. Rev. Stat. 1981, ch. 111½, par. 3101 et seq.). Similar materials shall be used in wall openings unless required otherwise for fire safety.

j) Thresholds and expansion joint covers shall be made flush with the floor surface to facilitate use of wheelchairs and carts.
k) Air dryers, or paper towel dispensers and waste receptacles shall be provided at all handwashing fixtures.
l) Where labeled fire doors are required, these shall be certified by an independent testing laboratory as meeting the construction requirements equal to those for fire doors in National Fire Protection Association (NFPA) Standard 80. Reference to a labeled fire door shall be construed to include labeled frame and hardware.
m) Radiation protection requirements of X-ray and gamma ray installations shall conform to the requirements of the Department of Nuclear Safety Rules for Protection Against Radiation (32 Ill. Adm. Code, Subchapter b) and should follow guidelines of NCRP reports #33 dated February 1968, and #49 dated September 1976. Provisions shall be made for testing and completed installation before use, and all defects must be corrected before use.
n) The minimum ceiling height shall be 8'-0", with the following exceptions:
    1) Boiler rooms, if provided, shall have ceiling clearance not less than 2'-6" above the main boiler header and connecting piping.
    2) Radiographic and other rooms containing ceiling-mounted equipment and including those with ceiling-mounted surgical light fictures shall have height required to accommodate the equipment and/or fixture.
    3) Ceilings in corridors, storage rooms, toilet rooms, and other minor rooms may be not less than 7'-8".
    4) Suspended tracks, rails, and pipes located in path of normal traffic shall be not less than 6'-8" above the floor.

o) Flammable Anesthetics are prohibited.
p) Cubicle curtains and draperies shall be noncombustible or rendered flame retardant and shall pass both the large and small scale tests of NFPA Standard 701.
q) Interior finish of walls and ceilings of all exit ways, storage rooms, and areas of unusual fire hazard shall have a flame spread rating of not more than 25.
r) Floor finish materials shall have a flame spread rating of not more than 75. If a separate underlayment is used with any floor finish material, the flame spread test assembly shall include the underlayment.
s) All interior finish materials shall have smoke developed rating of 450 or less. The use of materials known to produce large amounts of toxic gases shall be avoided.
t) Floor materials shall be easily cleanable and have wear resistance appropriate for the location involved.
    1) In all areas frequently subject to wet cleaning methods, floor materials shall not be physically affected by germicidal and cleaning solutions.
    2) Floors that are subject to traffic while wet, shall have a nonslip surface.
u) Wall finishes shall be washable and in the immediate area of plumbing fixtures, shall be smooth and moisture resistant.
v) Floor and wall penetrations by pipes, ducts, and conduits shall be tightly sealed to minimize entry of rodents and insects. Joints of structural elements shall be similarly sealed.
w) Ceilings shall be cleanable and those in sensitive areas such as surgical rooms shall be readily washable and without crevices that can retain dirt particles. These sensitive areas shall have a finished ceiling, covering all overhead ductwork and piping.
x) Finished ceilings may be omitted in mechanical and equipment spaces, shops, general storage areas, and

similar spaces, unless required for fire-resistive purposes.

y) Acoustical ceilings are recommended in corridors, multipurpose rooms, and waiting areas.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

* * *

SUBPART J: MECHANICAL

Section 205.1540 Air Conditioning, Heating and Ventilating Systems

a) The systems shall be designed to provide the comfort temperatures and humidities as recommended by ASHRAE Standards.

b) Air handling systems shall conform to "Installation of Air Conditioning and Ventilating Systems," NFPA 90A-1976.

c) For spaces not exceeding 25,000 cubic feet in volume, heating, air conditioning, and ventilating systems shall conform to "Standard for the Installation of Warm Air Heating and Air Conditioning Systems, NFPA 90-B, 1973, except return ducts shall be constructed of material equal to that specified for supply ducts, Chap. 2, paragraph 1.1., Duct Materials.

d) Outdoor air intakes shall be located as far as practical but not less than 15 feet from exhaust outlets of ventilation systems, combustion equipment stacks, medical-surgical vacuum systems, plumbing vent stacks or from areas which may collect vehicular exhaust and other noxious fumes.

e) All ventilation air outlets and inlets shall conform to NFPA 90A-Chapter 2, paragraph 3.2. Location of Outlets and Inlets.

f) The ventilation systems shall be designed and balanced to provide the ventilation and pressure relationships as shown in Table A.

g) The ventilation air supplied to the procedure rooms shall be delivered at or near the ceiling of the area served, and all exhaust or return air from the area

shall be removed near the floor level. At least two exhaust outlets shall be used in each procedure room.

h) All central ventilation or air conditioning systems shall be equipped with filters having efficiencies not less than those specified in the following table:

FILTER EFFICIENCIES FOR CENTRAL VENTILATION AND AIR CONDITIONING SYSTEMS IN AMBULATORY SURGICAL TREATMENT FACILITIES

Area Designation	Minimum Number of *Filter Beds*	Filter Efficiencies (Percent) Filter Bed *No. 1*	Filter Bed *No. 2*
Procedure and Recovery Rooms	2	25	90
All Other Areas	1	25	–

i) All filter efficiencies shall be average atmospheric dust spot efficiencies tested in accordance with the American Society of Refrigeration and Heating, Air Conditioning Engineers (ASHRAE) Standards 52-68.

j) For systems serving procedure and recovery rooms, filter bed No. 1 shall be located upstream of the conditioning equipment and filter bed No. 2 shall be located downstream of the supply fan and conditioning equipment including humidifiers.

k) Filter frames shall be durable and shall provide an airtight fit with the enclosing duct work. All joints between filter segments and enclosing duct work shall be gasketed or sealed to provide a positive seal against air leakage.

l) A manometer shall be installed across each filter bed serving procedure and recovery rooms.

m) Fire and smoke dampers shall be constructed, located and installed in accordance with the requirements of NFPA 90A.

n) All systems, regardless of size, which serve more than one smoke or fire zone, shall be equipped with smoke detectors to shut down fans automatically as specified in paragraph 4-3.1 of NFPA 90A.

o) The ventilation system for anesthesia storage rooms shall conform to the requirements of "Standard for Inhalation Anesthetics" NFPA 56A, including the gravity option ventilation system.

p) Boiler rooms shall be provided with sufficient outdoor air to maintain combustion rates of equipment and limit temperatures in working stations to 97° F Effective Temperature as defined by ASHRAE Handbook of Fundamentals.

q) Rooms containing heat-producing equipment, such as boiler rooms and heater rooms, shall be insulated and ventilated to prevent any floor surface above from exceeding a temperature of 100° F.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205. TABLE A General Pressure Relationships and Ventilation Rates of Ambulatory Surgery Area

Within Area Room Units Designation	Pressure Relationship to Adjacent Areas	Minimum Total Air Changes per Hour Supplied to Room	All Air Exhausted Directly to Outdoors	Recirculated
Procedure Room	+	15	Optional	No
Examination Room	0	6	Optional	Optional
Recovery Room	+	6	Optional	Optional
Medication Area	+	4	Optional	Optional
X-Ray Room	0	6	Optional	Optional
Soiled Workroom or Soiled Holding	–	10	Yes	No
Clean Workroom or Clean Holding	+	4	Optional	Optional
Darkroom	–	10	Yes	No
Toilet Room	–	10	Yes	No
Janitors' Closet	–	10	Yes	No
Sterilizer Equip. Rm.	–	10	Yes	No
Linen and Trash Rm.	–	1–	Yes	No
Laboratory	–	6	Optional	Optional
Soiled Linen Storage	–	10	Yes	No
Clean Linen Storage	+	2	Optional	Optional
Anesthesia Storage	0	8	Yes	No
Central Services Area				
Soiled Area	–	6	Yes	No
Clean Area	+	4	Optional	Optional
Equipment Storage	0	2	Optional	Optional

+ = Positive
– = Negative
0 = Equal

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

APPENDIX B

JUDGMENT – ORAL ARGUMENT

UNITED STATES COURT OF APPEALS
For the Seventh Circuit
Chicago, Illinois 60604

March 10, 1988.

Before

Hon. WILLIAM J. BAUER, *Chief Judge*
Hon. JOHN L. COFFEY, *Circuit Judge*
Hon. JESSE E. ESCHBACH, *Senior Circuit Judge*

RICHARD M. RAGSDALE, M.D., et al.,

Plaintiffs-Appellees,

No. 85-3242 vs.

BERNARD J. TURNOCK, Director of Illinois Department of Public Health, NEIL F. HARTIGAN, Attorney General, State of Illinois, GARY L. CLAYTON, Director of the Illinois Department of Registration and Education,

Defendants-Appellants.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 85-C-6011—**John A. Nordberg,** *Judge.*

This cause was heard on the record from the United States District Court for the Northern District of Illinois, Eastern Division, and was argued by counsel.

On consideration whereof, IT IS ORDERED AND ADJUDGED by this Court that with the exception of the portion of the injunction regarding the second trimester hospitalization requirement, which is VACATED AS MOOT, the preliminary injunction is AFFIRMED, in accordance with the opinion of this Court filed this date. Costs on appeal are assessed to appellants.

APPENDIX C

UNITED STATES COURT OF APPEALS
For the Seventh Circuit
Chicago, Illinois 60604

April 13, 1988.

Before

Hon. WILLIAM J. BAUER, *Chief Judge*
Hon. JOHN L. COFFEY, *Circuit Judge*
Hon. JESSE E. ESCHBACH, *Senior Circuit Judge*

RICHARD M. RAGSDALE, et al.,

Plaintiffs-Appellees,

No. 85-3242 v.

BERNARD J. TURNOCK, Director of the Illinois Department of Public Health, et al.,

Defendants-Appellants.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 85-C-6011—**John A. Nordberg,** *Judge.*

ORDER

The slip opinion in this matter issued on March 10, 1988, is amended as follows:

In footnote 6 at pages 14-15, strike the present third and fourth sentences and replace them with the following sentence.

However, the district court undertook a thorough examination of the traditional factors governing the granting of preliminary relief, i.e., the lack of an adequate remedy at law, irreparable harm, balance of harms, likelihood of success on the merits, and the public interest.

At page 3, line 10, strike the word "Providers" and substitute the word "Planning."

At page 5, line 13, strike the word "or" and substitute the word "for."

At page 32, lines 5-7, strike the citation "*Zbaraz v. Hartigan*, 763 F.2d 1532, 1545 (7th Cir. 1985), *appeal pending*, No. 85-673" and substitute the following "*Zbaraz v. Hartigan*, 763 F.2d 1532, 1545 (7th Cir. 1985) aff'd ___ U.S. ___, 108 S. Ct. 479 (1987)."

APPENDIX D

UNITED STATES COURT OF APPEALS
For the Seventh Circuit
Chicago, Illinois 60604

AMENDED ORDER

August 16, 1988.

Before

Hon. WILLIAM J. BAUER, *Chief Judge*
Hon. JOHN L. COFFEY, *Circuit Judge*
Hon. JESSE E. ESCHBACH, *Senior Circuit Judge*

RICHARD M. RAGSDALE, M.D., et al.,

Plaintiffs-Appellees,

No. 85-3242 v.

BERNARD J. TURNOCK, Director of Illinois Dept. of Public Health; NEIL F. HARTIGAN, Attorney General, State of Illinois; and GARY L. CLAYTON, Director of Illinois Dept. of Registration & Education,

Defendants-Appellants.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 85 C 6011—**John A. Nordberg**, *Judge*.

ORDER

On consideration of the petition for rehearing and suggestion for rehearing *en banc* filed by defendants-appel-

lants and the answer filed by plaintiffs-appellees, a vote was requested on the suggestion for a rehearing *en banc*. A majority of the members of the original panel voted to deny the petition for rehearing, and the suggestion of rehearing en banc failed by an equally divided court.* Judges Wood, Posner, Coffey, Manion, and Kanne voted to grant rehearing en banc. Accordingly,

IT IS ORDERED that the aforesaid petition for rehearing and suggestion for rehearing *en banc* is DENIED.

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* Judge Kenneth F. Ripple did not participate in the consideration of the suggestion for rehearing en banc.

APPENDIX E

UNITED STATES COURT OF APPEALS
For the Seventh Circuit
Chicago, Illinois 60604

August 12, 1988.

Before

Hon. WILLIAM J. BAUER, *Chief Judge*
Hon. JOHN L. COFFEY, *Circuit Judge*
Hon. JESSE E. ESCHBACH, *Senior Circuit Judge*

RICHARD M. RAGSDALE, M.D., et al.,

Plaintiffs-Appellees,

No. 85-3242 v.

BERNARD J. TURNOCK, Director of Illinois Dept. of Public Health; NEIL F. HARTIGAN, Attorney General, State of Illinois; and GARY L. CLAYTON, Director of Illinois Dept. of Registration & Education,

Defendants-Appellants.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 85 C 6011—**John A. Nordberg**, *Judge*.

ORDER

On consideration of the petition for rehearing and suggestion for rehearing *en banc* filed by defendants-appel-

lants and the answer filed by plaintiffs-appellees, a vote was requested on the suggestion for a rehearing *en banc*. A majority of the judges in regular active service did not vote to rehear the case *en banc*, and a majority of the members of the original panel voted to deny the petition for rehearing. Accordingly,

IT IS ORDERED that the aforesaid petition for rehearing and suggestion for rehearing *en banc* is DENIED.

Judge Kenneth F. Ripple did not participate in the consideration of the suggestion for rehearing en banc.

APPENDIX F

[Entered December 11, 1985]

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

RICHARD M. RAGSDALE, M.D., et al., Plaintiffs,

vs.

BERNARD J. TURNOCK, et al., Defendants.

No. 85 C 6011 — Judge Nordberg

CLASS CERTIFICATION AND PRELIMINARY INJUNCTION ORDER

This matter came to be heard upon plaintiffs' motion for class certification and upon plaintiff's motion for a preliminary injunction to enjoin and restrain defendants from enforcing § 16.1(a)-(e) of the Illinois Medical Practice Act, Ill. Rev. Stat. ch. 111, § 4433(a)-(e) ("the MPA"), the Illinois Ambulatory Surgical Treatment Center Act, Ill. Rev. Stat. ch. 111½, ¶ 157-8.1, *et seq.* ("the ASTC Act"), regulations promulgated under the ASTC Act, and the Illinois Health Facilities Planning Act, Ill. Rev. Stat. ch. 111½, § 1152-1168 ("the HFP Act"), against persons offering, performing, or desiring to offer or perform first or early second trimester abortions. The parties presented evidence and argument to the Court in hearings November 18-22 and November 26, 1985, and memoranda of law. Based upon the evidence, arguments and memoranda presented to the Court, on November 27, 1985 the Court issued a Memorandum Opinion and Order granting plain-

tiffs' motion for class certification and plaintiffs' motion for preliminary injunction.

Based upon this Court's November 27, 1985 Memorandum Opinion and Order and the findings of fact and conclusions of law therein, IT IS HEREBY ORDERED, ADJUDGED AND DECREED as follows:

1. This matter shall be maintained as a class action. The Court hereby certifies the following classes:

(a) A plaintiff class consisting of all physicians and surgeons who perform or desire to perform abortions in the State of Illinois;

(b) A plaintiff class consisting of all Illinois women of child-bearing age who desire or may desire an abortion sometime in the future;

(c) A defendant class consisting of all State's Attorneys in the State of Illinois.

2. Until further order of this Court, defendants Bernard J. Turnock, Neil F. Hartigan, and Gary L. Clayton, in their official capacities, and their successors, officers, agents, servants, employees, and attorneys, and those persons in active concert or participation with them, and Richard M. Daley and the other 101 State's Attorneys in Illinois, their successors, officers, agents, servants, employees and attorneys and those persons in active concert or participation with them, are hereby enjoined from the following actions:

(a) Enforcing § 16.1(a)-(e) of the MPA, Ill. Rev. Stat. ch. 111, § 4433(a)-(e);

(b) Enforcing or applying the ASTC Act, Ill. Rev. Stat. ch. 111½, ¶ 157-8.1 *et seq.*, or any of its provisions, or rules or regulations promulgated thereunder, against any person or facility to the extent such person or facility offers or performs, or desires to offer or perform, first and/or early second trimester abortions or other abortion-related gynecological procedures, such as a dilation and curettage;

(c) Enforcing or applying the HFP Act, Ill. Rev. Stat. ch. 111½, § 1152-1168, against any person or facility to the extent such person or facility offers or performs, or desires to offer or perform, first and/or early second trimester abortions or other abortion-related gynecological procedures, such as a dilation and curettage;

(d) Initiating any prosecution against, including but not limited to civil and administrative proceedings, or imposing any sanction upon any person who offers or performs or desires to offer or perform first and/or early second trimester abortions or other abortion-related gynecological procedures, such as a dilation and curettage, in violation of § 16.1(a)-(e) of the MPA, the ASTC Act, or any of its provisions, or rules and regulations promulgated thereunder, or the HFP Act.

3. This order shall be effective immediately and shall supplement this Court's November 27, 1985 order.

4. The $2,000 bond given by plaintiffs on November 27, 1985 and then approved by the Court shall also secure the preliminary injunction order contained herein.

ENTER: /s/ JOHN A. NORDBERG
United States District
Court Judge

Date: December 11, 1985

APPENDIX G

[Entered November 27, 1985]

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

RICHARD M. RAGSDALE, M.D., et al.,

Plaintiffs,

v.

BERNARD J. TURNOCK, et al.,

Defendants.

No. 85 C 6011 — Judge Nordberg

MEMORANDUM OPINION AND ORDER

Plaintiffs bring this action against defendants pursuant to 42 U.S.C. §§ 1983, 1988 and 28 U.S.C. §§ 2201, 2202, seeking declaratory and injunctive relief. Plaintiffs challenge the constitutionality of three Illinois statutes, and the regulations thereunder, which, plaintiffs contend, form a scheme that in effect requires all abortions to be performed in a hospital or its functional equivalent. Plaintiffs charge that this scheme violates the equal protection rights of Illinois physicians who perform or desire to perform abortions, and the privacy rights of Illinois women who desire or may desire to obtain an abortion.

This matter is now before the court on the motions of plaintiffs to certify two plaintiff classes and one defendant class, and for a preliminary injunction against defendants. The plaintiffs have moved the court to maintain the following classes: (1) a plaintiff class of "all duly licensed physicians and surgeons performing or desiring to perform pregnancy terminations in Illinois," represented by named plaintiff, Dr. Richard M. Ragsdale; (2) a plaintiff class of "all women in the state of Illinois of child-bearing age who desire or may desire an abortion sometime in the future," represented by named plaintiffs Sarah Roe and Margaret Moe; and (3) a defendant class of "the State's Attorneys for all of the counties of the state of Illinois," represented by named defendant, Richard M. Daley. The plaintiffs have also moved the court to enjoin defendants from enforcing, in derogation of a physician's right to perform, and a woman's right to obtain, first and early second trimester abortions, three Illinois statutes: (1) Section 16(1) of the Illinois Medical Practice Act ("MPA"), Ill. Rev. Stat. ch. 111, para. 4433(1); (2) the Ambulatory Surgical Treatment Center Act of Illinois ("ASTCA"), Ill. Rev. Stat. ch. 111½, para. 157-8.1 - 157-8.16, and the regulations promulgated thereunder; and (3) the Illinois Health Facilities Planning Act ("HFPA"), Ill. Rev. Stat. ch. 111½, para. 1151-1168, and the regulations promulgated thereunder.

The court has reviewed the pleadings of the parties dealing with the class certification motion. The court held a hearing on the motion for preliminary injunction on November 18-22 and 26, 1985. The court has reviewed the pleadings dealing with the preliminary injunction motion, and has heard the opening statements and closing arguments of counsel and the testimony of witnesses. The court has considered all the evidence presented, including the depositions of several witnesses who did not testify at the hearing. The court has drawn reasonable inferences from this evidence, and has evaluated the legal arguments presented by the parties. In judging the credibility of each witness and the weight to be given the testimony of each, the court has taken into account for each witness the intelligence, ability and opportunity to observe, the age, the memory, the manner while testifying, any interest, bias, or prejudice the witness may have, and the reasonableness of the testimony considered in the light of all the evidence in the case. The court has reviewed its extensive hearing notes and its references concerning credibility.

Based on all of the evidence and legal arguments presented, and for the reasons set forth below, the court grants, with some modification, plaintiffs' motion for certification of the three classes, and the court grants plaintiffs' motion for a preliminary injunction. A preliminary consideration of the challenged statutes and regulations, and of the facts, will greatly aid in the discussion of both motions. Therefore, the court now turns to the statutes and regulations, and to the facts.

I. The Challenged Statutes and Regulations

The statutes and regulations which plaintiffs challenge in this action present an unusual mixture of abortion-specific and general provisions.[1] First, section 16 of the MPA generally provides the grounds upon which the IDPH may revoke or suspend the medical license of any person. However, subsection (1), the only portion of section 16 which plaintiffs challenge, is abortion-specific. Under subsection (1), the IDPH may revoke or suspend the license of any physician who performs an "elective abortion" in any place other than an ASTC, a hospital, or a facility run by the state, the federal government, or a state university or college. Essentially, section 16(1) prohibits physicians from performing even one abortion in their offices, and requires physicians who wish to provide abortion services in non-hospital environments to comply with the ASTCA and HFPA.

The ASTCA defines what an ASTC is and provides for the licensure of all ASTCs. Section 3 of the ASTCA defines an ASTC as "any institution, place or building devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures or any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose." Thus, the ASTCA applies generally to all ASTCs devoted primarily to the performance of surgical procedures, regardless of the specific procedure performed, while at the same time the ASTCA singles out, for more strict regulation, facilities at which abortions are performed. The remainder of the ASTCA concerns, for the most part, the requirements and the procedure for obtaining an ASTC license. One other provision of the ASTCA deals specifically with abortion, and that is section 6.1, which requires any corporation operating an ASTC devoted primarily to providing facilities for abortion to have a physician, who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the ASTC, on the ASTC's board of directors as a condition to licensure of the ASTC.

The regulations promulgated pursuant to the ASTCA are comprehensive and detailed. They cover all aspects of the provision of abortion services, from personnel policies to physical plant requirements. Many of the regulations are abortion-specific. An entire section of the regulations, Subpart G, is abortion-specific. The regulations in subpart G include a prohibition upon the performance of abortions after the first trimester and reporting requirements for each abortion performed in an ASTC.

The physical plant requirements in the regulations cover building design, construction standards, physical requirements and mechanical and electrical systems. In effect, they require ASTCs to be the functional equivalent of small hospitals.[2] These regulations include, but are not limited to, the following:

(a) Regulation 205.1320(a), requires an ASTC to be "identifiably separate" from other [medical] facilities and functions.

(b) Regulation 205.1330, requires anyone seeking to build or substantially remodel an ASTC to submit work plans to the state for prior approval. These work plans include architectural drawings, structural drawings, and mechanical drawings (which include drawings of the heating, cooling, ventilation, plumbing, drainage, stand-pipe and electrical systems).

(c) Regulation 205.1360(a), requires that an examination room be at least 80 square feet in size.

(d) Regulation 205.1360(b), requires that a procedure room have a minimum clear area of 250 square feet.

(e) Regulation 205.1370(a), requires an ambulatory surgical treatment center to have a "control station" located to permit "visual surveillance of all traffic which enters the operating suite".

(f) Regulation 205.1370(k), requires that "staff and personnel facilities be provided for male and female personnel," including a lounge, lockers, separate toilets, and space for changing clothes.

(g) Regulation 205.1370(n), requires a separate janitorial closet exclusively for the surgical suite.

(h) Section 205.1380, requires an ambulatory surgical treatment center to establish a "diagnostic facility" equipped to perform diagnostic tests far more elaborate and complex than those performed during the course of a pregnancy termination.

(i) Regulation 205.1400 regulates the size of doors and halls to require that some corridors be at least 8 feet in width and that doors to procedure rooms be at least 3 feet 8 inches wide. These dimensions parallel the requirements for hospital corridors.

(j) Section 205.1540 regulates the air conditioning, heating and ventilation systems to require (a) specific filter efficiencies and (b) air flow systems "balanced" to comply with the detailed ventilation and pressure relationships established by the regulation. Different pressure relationships and air change requirements are specified for the following areas: (1) the procedure room, (2) the examination area, (3) the recovery room, (4) the instrument cleaning room, (5) the toilet room, (6) the janitors' closet, (7) the linen and trash area, (8) the anesthesia storage area, (9) the equipment storage area, (10) the clean linen and storage area, (11) the soiled linen storage area, (12) the laboratory area, and (13) miscellaneous other areas.

As can be seen, these regulations are extremely detailed. The regulations, without question, cause abortion providers to incure great construction or renovation costs.

The HFPA requires all "health Care facilities," which includes all ASTCs, to obtain a "permit," or certificate of need, before acquiring major medical equipment or constructing or modifying a health care facility. HFPA §§ 3, 5. The procedure which the HFPA established for acquiring a certificate of need is as follows: (1) the applicant must submit a comprehensive application to the Illinois Health Facilities Planning Board ("Board"), HFPA § 6; (2) if there is an Areawide Health Planning Organization, the Board forwards the application to this organization for a period of review which may last up to 120 days, HFPA § 8; (3) the Areawide Health Planning Organization, or the IDPH, must provide an opportunity for a public hearing on the application, and may schedule that hearing up to 90 days after the receipt of a complete application, HFPA § 8; and (4) ultimately, the Board will determine whether to grant or deny the application for a certificate of need based on factors such as the applicant's ability to provide a proper standard of health care service for the community, the economic feasibility of the project, and the project's consistency with the public interest and the orderly and economic development of such facilities, HFPA § 6.[3]

II. The Facts

The uncontroverted facts are as follows. Dr. Ragsdale is a licensed Illinois physician. He is the Director of the Northern Illinois Women's Center ("NIWC"), which is located in Rockford, Illinois. The NIWC provides gynecological, family planning and abortion services to women in northwest Illinois.

Since it opened in 1973, the NIWC has been the only provider of abortion services in the large area of northwest Illinois. This geographic area extends west to Chicago, east to Iowa, north to Wisconsin, and south to

Peoria. The NIWC offers first trimester and early second trimester "Dilation and Evacuation" abortions, all performed with a local anesthetic. The NIWC provides either reduced fee or free abortion services to indigent women. In 1984, physicians at the NIWC performed 3,480 abortions. Few complications resulted.[4]

The NIWC is currently licensed under the ASTC, and has been so since 1973, although at no time has the NIWC fully complied with the ASTCA and its regulations.[5] The current location of the NIWC is the Rockford Medical Arts Building, which is operated by the Rockford Services Company.

In early February, 1985, the Rockford Services Company informed Dr. Ragsdale that his lease would not be renewed. The fundamental reason the Rockford Services Company did not renew Dr. Ragsdale's lease, as set out in the telephonic deposition of Mr. Delts, the President of the Rockford Services Company, is that the premises of the NIWC are needed as office space for physicians that refer more patients to the adjoining Rockford Memorial Hospital. Deposition of William Delts, p. 15. Another factor in the decision, however, was the determination that it would cost approximately $240,000 for the building to be brought into compliance with the ASTCA and its regulations. *Id.* at 8, 9, 14.

Since the Rockford Services Company informed him that his lease would not be renewed, Dr. Ragsdale has attempted to find new facilities and secure a certificate of need for such facilities. Dr. Ragsdale, for reasons set forth below in detail, has not been able to secure a relocation site for the NIWC. On December 31, 1985, the NIWC must vacate its premises in the Rockford Medical Arts Building. At that time, because of a lack of a relocation site, the NIWC will be forced to close altogether.

Margaret Moe is a registered nurse, and she currently operates two medical facilities, one in Elgin, Illinois, and another in Palatine, Illinois. The Elgin facility is in Kane County, and the Palatine facility is in Cook County. Margaret Moe's facilities offer complete family planning education and medical care, including the prescription of contraceptives, pre-natal care and delivery-assistance for pregnant women.

Margaret Moe receives approximately 60 requests for abortions per week at her clinics. She would like to offer abortion services at her facilities, and the licensed physicians she employs are competently trained and willing to perform safe abortions. However, Margaret Moe's facilities do not comply with the physical plant, structural and administrative requirements of the ASTCA and its regulations. As set forth more fully below, Margaret Moe has not, and cannot, renovate her existing facilities or construct new facilities that would comply with the ASTCA and its regulations because of the prohibitive cost of such a project.

The two other named plaintiffs are Sarah Roe and Jane Doe. Sarah Roe is a female citizen of the United States, of child-bearing age and a resident of Rockford, Illinois. She is the mother of two children. Ms. Roe had an abortion at the Northern Illinois Women's Center for which she was charged only a minimal fee because of her current indigent financial situation. She may need another abortion in the future. Jane Doe is a female citizen of the United States and of child-bearing age. She is a resident of Rockford, married and the mother of several children. From other doctors in the Rockford area, Ms. Doe learned that uterine fibroids associated with a recent pregnancy posed a serious risk to her health; she was told that it was unlikely she would be able to carry her pregnancy past five months. Despite the severe pain and emotional trauma associated with this health threat, Ms. Doe was refused abortion services by several doctors in Rockford. Finally she was referred to Dr. Ragsdale at the NIWC from whom Ms. Doe received an abortion.

III. Motion For Class Certification

As stated above, plaintiffs have moved the court to maintain the following classes: (1) a plaintiff class of "all

duly licensed physicians and surgeons performing or desiring to perform pregnancy terminations in Illinois," represented by named plaintiff, Dr. Ragsdale; (2) a plaintiff class of "all women in the state of Illinois of child-bearing age who desire or may desire an abortion sometime in the future," represented by named plaintiffs, Margaret Moe and Sarah Roe; and (3) a defendant class of "the State's Attorneys for all of the counties of the State of Illinois," represented by named defendant, Richard M. Daley. Defendants Bernard J. Turnock, Director of the Illinois Department of Public Health ("IDPH"), Neil F. Hartigan, Attorney General of Illinois, and Gary L. Clayton, Director of the Illinois Department of Registration and Education ("IDRE"), through their counsel, have opposed the certification of the plaintiff classes. In addition, defendant Richard M. Daley, through his attorney, has objected to being named as the representative of the defendant class of Illinois State's Attorneys.

Rule 23 of the Federal Rules of Civil Procedure governs the certification of classes in federal courts. In order for a class to be certified, it must meet the four criteria set out in 23(a) and must also qualify under any one of the subsections of 23(b). The four criteria of 23(a) are that (1) the class is so numerous as to make joinder impracticable; (2) there are common questions of law or fact; (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and (4) the representative parties will fairly and adequately protect the interests of the class. Subsection (b) provides that a class action may be maintained if the prosecution of separate actions would create certain risks, the party opposing the class has acted on grounds generally applicable to the class, making injunctive and declaratory relief appropriate, or the court finds that the questions of law or fact common to the members of the class predominate and that a class action is the superior method for adjudication of the controversy. The burden of establishing these class requirements rests on plaintiffs. *Eggleston v. Chicago Journeymen Plumbers Local Union No. 130*, 657 F.2d 890, 895 (7th Cir. 1981), *cert. denied*, 455 U.S. 1017 (1982). The

court now considers whether the proposed classes meet the class action requirements of Rule 23.

A. The Plaintiff Class of Physicians

This proposed class consists of all duly licensed physicians and surgeons performing or desiring to perform pregnancy terminations in Illinois, and the proposed representative of this class is Dr. Ragsdale. The court finds that the requirements of Rule 23 are met as to this class and its representative, Dr. Ragsdale.

First, this proposed class of plaintiffs is so numerous that it would be impracticable to individually join all of its members. Although plaintiffs did not present direct evidence of the number of class members, plaintiffs did state that there are approximately 65,860 abortions performed in Illinois annually. Plaintiffs' Motion to Maintain Class Actions, p. 3. In addition, during the hearing on the motion for preliminary injunction, plaintiff Margaret Moe stated that the physicians she employs in her two Illinois health care clinics desire to perform abortions, and that she knew of physicians in Cook, Kane and DuPage counties who would also perform abortions, but for the challenged statutes and regulations.[6] This evidence amounts to more than mere speculation or conclusory allegations as to the numerousity of the class. *See Valentino v. Howlett*, 528 F.2d 975, 978 (7th Cir. 1976). Also, although an exact number of class members has not been determined, due to the difficulty in making such a determination, this does not preclude class certification. *Vergara v. Hampton*, 581 F.2d 1281, 1284 (7th Cir. 1978), *cert. denied*, 441 U.S. 905 (1979). The court finds that plaintiffs have presented sufficient evidence of the numerousity of this class of physicians.

Second, there are questions of law or fact common to the members of this proposed class. Not all factual or legal questions raised in a lawsuit need be common, so long as a single issue of law or fact is common to all class members. *Thillens, Inc. v. Community Currency Exchange*

Assoc. of Illinois, 97 F.R.D. 668, 677 (N.D. Ill. 1983). Also, variance in class members' positions on the common issue should not be dispositive of the decision to certify the class action. *Id.* Here, all Illinois physicians who perform, or desire to perform, abortions are subject to the challenged statutes and regulations. The question of law common to all physicians in this class is whether the statutes and regulations unconstitutionally impede the equal protection right of physicians in this class to practice their profession.

Third, Dr. Ragsdale's claims are typical of the claims of the class. As a licensed Illinois physician who performs abortions in the course of his regular medical practice, Dr. Ragsdale is subject to the challenged statutes and regulations in the same manner as all other Illinois physicians performing, or desiring to perform, abortions.[7]

Fourth, Dr. Ragsdale will fairly and adequately protect the interests of the class. The test of adequacy of representation is two-pronged: (1) the representative must be able to conduct the litigation; and (2) the representative's interests must not be antagonistic to those of the class members. *Thillens*, 97 F.R.D. at 679. Dr. Ragsdale has clearly demonstrated his ability to conduct the litigation in the preliminary injunction proceedings. Furthermore, his attorneys have considerable experience in civil rights litigation. Also, Dr. Ragsdale does not have interests antagonistic to the interests of the class.

Finally, this proposed class meets the requirements of 23(b)(2), as the defendants, in either promulgating, administering or enforcing the challenged statutes and regulations, have acted on grounds generally applicable to the class, making injunctive and declaratory relief appropriate. Here, plaintiffs seek only injunctive and declaratory relief.[8] Finding this class meets the requirements of Rule 23, the court therefore certifies this plaintiff class and finds Dr. Ragsdale to be an adequate representative.

B. The Plaintiff Class of Women

This proposed class consists of all women in Illinois of child-bearing age who desire or may desire an abortion sometime in the future, and the proposed representatives are Margaret Moe and Sarah Roe. The court finds that the requirements of Rule 23 are met as to this class; however, the court appoints, as the named representatives of this class, Margaret Moe and Dr. Ragsdale. The defendants contend that Sarah Roe does not have standing to assert her own privacy rights, let alone the privacy rights of the proposed class members. Such contention need not detain the court at this time, and the court does not decide here whether Sarah Roe does have standing, for it is clear that Margaret Moe and Dr. Ragsdale have standing to litigate this lawsuit on behalf of themselves as well as on behalf of the proposed class of Illinois women. *See, e.g., Westchester Women's Health Organization v. Whalen*, 475 F. Supp. 734, 737 (S.D. N.Y. 1979). The court now turns to the requirements of Rule 23.

As stated previously, approximately 65,860 abortions are performed in Illinois annually. Clearly, the proposed class is so numerous as to make joinder impracticable. Also, as noted before, the difficulty in determining the exact number of class members does not preclude class certification.

There is a question of law common to all members of the proposed class. The common question of law is whether the challenged statutes and regulations unconstitutionally burden the right to privacy of the class members.

As for the typicality of the claims of Dr. Ragsdale and Margaret Moe, and the adequacy of their representation, the court finds that both of these named plaintiffs clearly have standing to assert the claims of Illinois women who desire, or may desire, to obtain an abortion. In *Friendship Medical Center, Ltd. v. Chicago Board of Health*, 505 F.2d 1141, 1145-1148 (7th Cir. 1974), *cert. denied*, 420 U.S. 955 (1975), the Seventh Circuit held that both the physician and the corporate plaintiff had stand-

ing to assert that the abortion regulations unduly infringed upon the privacy rights of their patients. In so holding, the court relied on *Doe v. Bolton*, 410 U.S. 179 (1973), as making it clear that physicians threatened with criminal liability for the performance of an "illegal" abortion do have a sufficient interest to challenge the validity of a State's abortion law.

In the present case, Dr. Ragsdale and Margaret Moe are not threatened with criminal prosecution, and Margaret Moe is not a physician. However, as owners and operators of medical centers, both are threatened, under the ASTCA and the HFPA, with liability for a "business offense," punishable by a fine of $10,000.00 for each "violation." Each day may constitute a separate violation. ASTCA § 12, HFPA § 14. In addition, under the ASTCA, the IDPH may deny, suspend or revoke an ASTC license and may even "immediately" close a facility under certain conditions, and, under the HFPA, the Illinois Health Facilities Planning Board may deny an application for a permit needed for the acquisition of major medical equipment or the construction or modification of a health care facility. ASTCA §§ 7, 9(a), HFPA § 10.[9] Also, Dr. Ragsdale is threatened, under the MPA, with the revocation of his medical license. MPA § 16(1). Clearly, both Margaret Moe and Dr. Ragsdale have an extremely concrete interest in the outcome of this litigation, and both therefore have standing to assert the interests of their patients in this action. *See Birth Control Centers, Inc. v. Reizen*, 508 F. Supp. 1366, 1369 (E.D. Mich. 1981) (holding that corporate and physician plaintiffs have standing to assert the claims of their patients), *aff'd in part, vac. in part*, 743 F.2d 352 (6th Cir. 1984).

As the named plaintiffs have standing to assert the claims of this proposed class of women, the court finds that the requirements of typicality and adequacy of representation have been met.[10] The court finds that the named plaintiffs are adequate representatives despite the fact that they are not technically members of the proposed plaintiff class. *See Undergraduate Student Association v.*

Peltason, 359 F. Supp. 320, 323 (N.D. Ill. 1973) ("As to [the organization's] representation of its members, it would be absurd to hold that an organization has standing in the constitutional sense, but is barred by the technical requirements of Rule 23, Fed.R.Civ.P. [citations omitted].") In fact, these representatives seem particularly appropriate in light of the fact that persons remain in this class for only a short period of time.

As the above discussion establishes, this proposed plaintiff class meets the requirements of section (a) of Rule 23. The proposed class also meets the requirements of Rule 23(b)(2), for the same reasons as discussed with regard to the plaintiff class of physicians. The court therefore certifies this plaintiff class of Illinois women of childbearing age who desire, or may desire, to obtain an abortion, and finds Margaret Moe and Dr. Ragsdale to be adequate representatives of the class.

C. The Defendant Class of State's Attorneys

This defendant class consists of the State's Attorneys for all of the 102 counties in the State of Illinois. The named representative is Richard M. Daley, State's Attorney for Cook County, Illinois.

Rule 23 unquestionably authorizes the certification of defendant classes. Section 23(a) provides, in part:

> One or more members of a class may sue *or be sued* as representative parties on behalf of all only if . . . (3) the claims *or defenses* of the representative parties are typical of the claims *or defenses* of the class . . . [emphasis added].

Fed.R.Civ.P. 23(2). In addition, Section 23(b) provides that a class action may be maintained if the requisites of Section 23(a) are met, and "the prosecution of separate actions by *or against* individual members of the class" would create certain risks (emphasis added). *See Thillens*, 97 F.R.D. at 673.

Indeed, in other similar cases in which the plaintiffs have questioned the constitutionality of various sections of the Illinois abortion laws, the courts have certified defendant classes of State's Attorneys, with the State's Attorney of Cook County as the named representative. *Zbaraz v. Hartigan*, 584 F. Supp. 1452, 1454 (N.D. Ill. 1984), *modified on other grounds*, 763 F.2d 1532 (7th Cir. 1985) (challenging the Parental Notice Abortion Act and designating *Richard M. Daley* as the representative of all the State's Attorneys of all the counties in Illinois); *Wynn v. Scott*, 449 F. Supp. 1302, 1306 (N.D. Ill. 1978), *aff'd sub nom., Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979) (challenging certain sections of the Abortion Act of 1975); *Wynn v. Scott*, 448 F. Supp. 997, 1000 (N.D. Ill. 1978), *aff'd sub nom., Wynn v. Carey*, 582 F.2d 1375 (7th Cir. 1978) (challenging the Illinois Abortion Parental Consent Act of 1977). However, there is no indication that the State's Attorney of Cook County, Illinois objected to representing the class of all Illinois State's Attorneys in these cases.

In the present case, Richard M. Daley does object to being named as the representative of a defendant class of Illinois State's Attorneys. In his answer to the plaintiffs' complaint, Mr. Daley "denie[d] that he should be a class representative" and stated that (1) the class of State's Attorneys of all 102 counties in Illinois is not so numerous that joinder of all members is impracticable; (2) it is incorrect to assume that each State's Attorney in Illinois would assert the same defense to the plaintiff's claims; and (3) he, through his assistants, generally depends on the Illinois Attorney General for the defense in cases challenging Illinois abortion laws. Defendant Daley's Answer, pp. 2, 3. Mr. Daley, through his attorney, repeated his objection to representative status in a later notice of October 30, 1985 and at the hearing on plaintiffs' motion for preliminary injunction.

In *Thillens*, 97 F.R.D. 668, and in *Research Corp. v. Pfister Associated Growers, Inc.*, 301 F. Supp. 497 (N.D. Ill. 1969), *appeal dismissed sub nom., Research Corp. v.*

Asgrow Seed Co., 425 F.2d 1059 (7th Cir. 1970), the named defendant likewise objected to representing the defendant class. In both cases, the courts certified the defendant classes and found the named defendants to be adequate representatives. According to the *Research Corp.* court, the defendants' objection to being the named representatives "is hardly enough to overcome the overwhelming evidence of their ability and intention to challenge the plaintiff's assertions" and "this factor of 'desire,' as opposed to ability should not be given more than token weight." *Research Corp.*, 301 F. Supp. at 499. *See also Thillens*, 97 F.R.D. at 679.

The *Thillens* court, however, did discuss the special due process concerns which arise upon a motion for certification of a defendant class.[11] As the court noted, the Supreme Court has balanced the concurrent goals of preserving fundamental fairness to absent members of a defendant class and promoting judicial economy "by holding that due process is satisfied and absent members of a class are bound so long as the interests of the absentees are adequately represented [citations omitted]." *Thillens*, 97 F.R.D. at 674. As seen above, the adequacy of the named representative is not an additional requirement, but a requirement already found in Rule 23. The *Thillens* court, however, demanded that this requirement be "strictly observed" as to defendant classes, because of the special due process concerns. With this in mind, this court now turns to the requirements for class certification found in Rule 23.

First, the court finds that the class of 102 State's Attorneys, who are dispersed through the State of Illinois, is so numerous that it would be impracticable to individually join its members. Second, the court finds that there are questions of law common to the proposed class of defendants. Here, the plaintiffs' claim is that the challenged statutory and regulatory scheme is unconstitutional—that it violates the privacy rights of women desiring to obtain abortions and the equal protection rights of physicians desiring to provide abortion services. The overriding

common issue of law, therefore, is the constitutionality of the challenged statutes and regulations.

Third, the court finds that the defenses of Richard M. Daley are typical of the defenses of the class of Illinois State's Attorneys. Obviously, the primary defense of Mr. Daley and of all the State's Attorneys in this case will be that the challenged statutes and regulations are indeed constitutional.[12]

Finally, the court finds Mr. Daley to be an adequate representative of the interests of the class. Mr. Daley, through his staff, has already demonstrated, in the preliminary injunction hearing, his ability to conduct the litigation. Mr. Daley is sued in his official capacity; therefore, no serious question can be raised regarding his ability to carry the expense of the class defense. Furthermore, Mr. Daley and his staff have considerable litigation experience. Also, Mr. Daley is a member of the proposed class, and his interests in the subject matter of the litigation are not antagonistic to the interests of the members of the class of State's Attorneys.

The court therefore finds that this proposed class meets the requirements of section (a) of Rule 23. This class also meets the requirements of section (b)(1) of Rule 23. The prosecution of separate actions against individual members of the defendant class would indeed create a risk of inconsistent or varying adjudications, and plaintiffs would thereby be faced with incompatible standards of conduct. Having found that the requirements of Rule 23 have been met as to this class, the court now certifies this defendant class of Illinois State's Attorneys, represented by named defendant Mr. Daley.

IV. Motion For Preliminary Injunction

As stated above, plaintiffs have moved the court to preliminarily enjoin defendants from administering and enforcing, in derogation of the equal protection rights of physicians who perform, or desire to perform, abortions and privacy rights of women who desire, or may desire,

to obtain an abortion, Section 16(1) of the MPA, the ASTCA and the regulations thereunder, and the HFPA and the regulations thereunder. In ruling on a motion for a preliminary injunction, the court must consider the following factors: (1) whether the plaintiffs have no adequate remedy at law and will suffer irreparable harm if the court does not grant the preliminary injunction; (2) whether the irreparable harm the plaintiffs will suffer outweighs any irreparable harm that may reflect on the defendants if the court issues the injunction; (3) whether the plaintiffs have shown a "better than negligible" likelihood of succeeding on the merits; and (4) whether the injunction will disserve the public interest. *Roland Machinery Co. v. Dresser Industries*, 749 F.2d 380, 386-387 (7th Cir. 1984). Here, the court finds that all four factors weigh decidedly in favor of issuing a preliminary injunction.

A. No Adequate Remedy At Law And Irreparable Harm

Plaintiffs in this case have demonstrated that they will indeed experience irreparable harm should the court not issue this injunction. The challenged statutory and regulatory scheme, as written and as enforced, has the effect of raising the cost and limiting the availability of abortions. The scheme forces complying facilities to raise their fees, possibly beyond the economic means of some women, discourages other non-complying facilities from offering abortion services, and makes it difficult, if not impossible, for current abortion facilities to move or new abortion facilities to be constructed.

In *Fox Valley Reproductive Health Care v. Arft*, 446 F. Supp. 1072, 1073-1074 (E.D. Wisc. 1978), the court found that the plaintiff abortion clinic sufficiently established irreparable harm. The town ordinance challenged in that case is very similar to the ASTCA and its regulations here, in that (1) the town ordinance applied generally to any nonhospital facility at which surgical, diagnostic, or therapeutic procedures were performed; (2) certain provisions applied specifically to abortion clinics; and (3) the

ordinance was comprehensive, regulating licensing, building plans and specifications, supplies and equipment, medical policies and procedures, record keeping, patient care, and physician and nurse qualifications. The plaintiff in *Fox Valley* contended that irreparable harm was threatened, because the high cost of bringing the facility in compliance with the ordinance would force it to raise its current fee of $150 to a fee of between $300 and $500, an amount which would be beyond the economic means of poor women. The court held that this contention, "in conjunction with the solicitude courts have shown for a woman's right to freedom from interference in deciding whether to seek an abortion," supported a finding that irreparable harm was threatened. *Fox Valley*, 446 F. Supp. at 1074.

In the present case, plaintiffs have also demonstrated that the extensive regulations force those offering abortion services to raise their fees for abortion services.[13] This may indeed place the abortion procedure beyond the economic means of some women.

Plaintiffs have also demonstrated that the extensive ASTCA regulations discourage or "chill" those desiring to offer abortion services from opening an abortion facility or from adding abortion services to the services they already provide at their facilities. Margaret Moe testified at the hearing that she has desired to offer abortion services at the two health care clinics she operates since 1974. She contacted the IDPH on various occasions from 1974-1982, and was told on each occasion that abortion facilities must secure an ASTC license and comply with the ASTCA regulations.[14] Because of the extensive, expensive, and, indeed, prohibitive physical plant requirements in the regulations, Margaret Moe decided she could not offer abortion services at her clinics, and she still does not offer abortion services at her clinics.

In addition, plaintiffs have also shown that the certificate of need requirement of the HFPA makes it extremely difficult, if not impossible, for those desiring to provide abortion services to construct a facility or move to a new location. Under the certificate of need process set

out in the HFPA, those desiring to open or move to a new facility must complete a lengthy, detailed application,[15] in which the applicant must disclose the fact that abortions will be performed at the proposed facility and must identify the ownership of the proposed facility. The general public may obtain a copy of this application through the state freedom of information law.[16] Ill. Rev. Stat. ch. 116, para. 201, *et seq.* Also, as part of the certificate of need process, the "recognized areawide health planning organization" or the IDPH must provide an opportunity for, and notice of, a public hearing "for the purpose of allowing the applicant and any interested person to present public testimony concerning the approval, denial, renewal or revocation of the [certificate of need]." HFPA § 8.

Given the current climate of the abortion debate, placing information in the hands of the public, such as the ownership of a facility in which persons propose to provide abortion services, subjects both the owner of the building and the proposed provider to the possibility of harrassment and even threats of violence to themselves, their families and their friends.[17] In the case of Dr. Ragsdale, after the public received notice of a hearing on a proposed new site for the NIWC, but before the hearing took place, the landlord of the proposed site, with whom Dr. Ragsdale had an informal agreement, withdrew the site. Dr. Ragsdale secured a second site before the public hearing. Dr. Ragsdale entered a formal agreement with the landlord of this second site. Approximately 1,200 people attended the hearing on March 14, 1985. The hearing began at 7:00 p.m. with a statement by Dr. Ragsdale announcing the NIWC's proposed move. No other statement could be heard for the rest of the hearing, which lasted until 10:00 p.m., because of the shouting and generally riotous atmosphere. Friends of Dr. Ragsdale, fearing for his safety, escorted the Ragsdale family from the hearing. The landlord for the second site withdrew the site within 48 hours of the hearing, despite the formal agreement he had entered with Dr. Ragsdale. The areawide health planning organiza-

tion in the area of the proposed new sites of the NIWC did eventually determine that there was a need for the NIWC.[18] However, by the time this determination was made, Dr. Ragsdale no longer had a site to which he could move the NIWC. As it now stands, the NIWC, the only outpatient abortion facility in all of northwest Illinois, will close December 31, 1985 without a relocation site.

In her testimony at the hearing, Margaret Moe pointed out yet another way in which the certificate of need procedure under the HFPA impedes efforts to provide abortion services. Recently, many hospitals have had difficulty filling their available beds because of the emphasis on outpatient health care. With many empty hospital beds, it may be difficult for those who desire to provide abortion services to establish a "need" for an outpatient abortion facility.

As the above discussion makes clear, the challenged statutes and regulations do place a very real and a very heavy burden on the right of a woman to decide to terminate her pregnancy. The effect of the statutory and regulatory scheme is to increase the cost of abortions and decrease their availability. As a result of the scheme, Margaret Moe does not provide abortion services at her two Illinois clinics even though the physicians at the clinics are ready, willing, and able to perform abortions, and even though approximately sixty patients a week at the clinics request an abortion. Also, as a result of the scheme, the NIWC, the only outpatient abortion facility in northwest Illinois, will close at the end of this year without a relocation site.

The effect on women desiring to terminate their pregnancies, as clarified by the hearing testimony of Margaret Moe, is enormous. First, many women are not able to obtain an abortion in their own community, and they may find it difficult to secure a means of transportation to the nearest abortion facility, which may, in fact, be quite a distance from their community.[19] Having to make travel plans, arrange a day off and negotiate a loan, if needed, and then actually having to travel some distance to an

abortion facility may delay the abortion and thereby increase the health risk or prevent the abortion altogether. Also, travelling a distance subjects a woman to greater expense, as the woman must pay for the cost of transportation and may need to hire a babysitter or miss a day of work and lose that day's pay. In addition, other factors affecting a woman's decision to terminate her pregnancy, such as her confidence in the competency of the physician performing the abortion and her ability to return for follow-up care, would be adversely affected if the woman were required to travel a great distance to obtain an abortion.[20]

The court finds that plaintiffs have clearly established that irreparable injury will result if the injunction is not issued. *See Doe v. Charleston Area Medical Center*, 529 F.2d 638, 644 (4th Cir. 1975) ("*Roe v. Wade* and *Doe v. Bolton* . . . establish beyond argument that denial under color of law of the right to abort, implicit in the right to be let alone, constitutes irreparable injury."). *Accord, Gary-Northwest Indiana Women's Services, Inc. v. Bowen*, 496 F. Supp. 894, 902 (N.D. Ind. 1980).

The court finds that plaintiffs have established irreparable injury despite the argument of defendants that irreparable injury is not established because the IDPH does not enforce certain sections of the statutes and certain regulations. The State asserted in the hearing that the IDPH does not currently enforce the following statutes and regulations: (1) MPA § 16(1), requiring abortions to be performed in an ASTC or hospital; (2) ASTCA § 3(A), defining an ASTC as including any facility in which a medical procedure is utilized to terminate a pregnancy, regardless of whether the facility is primarily devoted to this purpose; (3) Regulation 205.740, prohibiting the performance of other than first trimester abortions in ASTCs; and (4) Regulation 205.760, requiring a report of each abortion procedure performed in an ASTC.

However, the IDPH has on no occasion formally notified physicians or abortion providers of its decision not to enforce these provisions. Also, the IDPH has not attempted

to amend the regulations or introduce amendatory legislation in the Illinois legislature. With no formal commitment of nonenforcement, the statutory and regulatory requirements, even if not in fact enforced, clearly "chill" potential abortion providers. Moreover, even if there were a formal nonenforcement agreement, the discussion above demonstrates that plaintiffs have established irreparable injury resulting from the statutory and regulatory scheme, as written *and as enforced*.

The court notes, at this time, the irony implicit in the defendants' nonenforcement argument. At the preliminary injunction hearing, Dr. Hern, an expert on abortion practice, testified that most important factor in determining the safety of an abortion is the skill and experience of the physician. According to Dr. Hern, a physician who performs only a few abortions a year will be less skilled than physicians with a practice "primarily devoted" to the performance of abortions. Under the statutory and regulatory scheme, as defendants contend it is now enforced, physicians performing thousands of abortions yearly are more strictly regulated than physicians performing a few abortions a year.

B. Harm To The Plaintiffs Outweighs Any Harm To Defendants

The threatened harm to the plaintiffs clearly outweighs any possible harm defendants may suffer if the court issues the preliminary injunction. Indeed, it is difficult to discern exactly what, if any, harm will befall defendants upon the issuance of this injunction, which will merely prevent defendants from enforcing the challenged statutes and regulations. *See e.g., Fox Valley*, 446 F. Supp. at 1074.

C. Likelihood of Success On The Merits

In the landmark case of *Roe v. Wade*, 410 U.S. 113 (1973), the Supreme Court established that the right of privacy, grounded in the concept of personal liberty guaranteed by the Constitution, encompasses a woman's right

to decide whether to obtain an abortion. *Id.* at 153. At the same time, the Court acknowledged that this fundamental right "is not unqualified and must be considered against important state interests in abortion." *Id.* at 154. However, as pointed out in *Roe*, 410 U.S. at 155, and more recently in *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 427 (1983), restrictive state regulation of the right to choose abortion, as with other fundamental rights, must be supported by a compelling state interest.

In *Roe*, the Court identified the relevant state interests and the point at which those interests become compelling. According to the Court, the state has an interest in the health of the mother, and this interest becomes compelling at approximately the end of the first trimester. After the first trimester, the state may, in promoting this interest, "regulate the abortion procedure in ways that are reasonably related to maternal health." *Roe*, 410 U.S. at 164. Until that time, a pregnant woman must be allowed, in consultation with her physician, to decide to abort and to effectuate that decision "free of interference by the State." *Id.* at 163; *Akron*, 462 U.S. at 429-430.

The Court in *Roe* based its identification of the end of the first trimester as the "compelling point" on the finding that, according to medical literature available in 1973, first trimester abortions are as safe for a woman as normal childbirth. *Roe*, 410 U.S. at 163. In *Akron*, the Court noted that medical developments in the past decade "have extended the period in which abortions are safer than childbirth." *Akron*, 462 U.S. at 429, n. 11.[21] Still, the *Akron* Court held it "prudent . . . to retain *Roe*'s identification of the beginning of the second trimester *as the approximate time* at which the State's interest in maternal health becomes sufficiently compelling . . . (emphasis added)." *Id.* The court now turns to the *Roe* trimester standard, as interpreted in *Akron* and other cases, to provide the legal framework for the constitutional evaluation of the challenged statutes and regulations.

First, the court notes that the statutes and regulations here apply to all facilities in which any abortions are performed. None of the statutes or regulations exclude from their scope facilities in which first or early second trimester abortions are performed. However, this does not mean that the statutes and regulations are per se unconstitutional. As the *Akron* court noted, certain State regulations that have no "significant impact" on a woman's exercise of her abortion right during the first trimester may be permissible where justified by important State health objectives. *Akron*, 462 U.S. at 430. *See Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976) (upholding regulations which applied to first trimester abortions and required that a patient give written consent prior to the abortion, and that records be kept of all abortions); *Connecticut v. Menillo*, 423 U.S. 9 (1975) (upholding a statute requiring that only licensed physicians perform abortions, including first trimester abortions).

Neither does *Roe* stand for the proposition that any general medical regulation which applies to the performance of first and early second trimester abortions is per se constitutional.[22] As the Seventh Circuit stated in *Friendship Medical Center, Ltd. v. Chicago Board of Health*, 505 F.2d 1141, 1153-1154 (7th Cir. 1974), *cert. denied*, 420 U.S. 955 (1975):

> Furthermore, any proposed regulation, even if applied universally to all similar medical procedures, because of the fundamental right of a woman to procure an abortion during the first trimester, would have to meet a compelling governmental interest requirement. Thus, any general health regulations which would apply to first trimester abortions would have to be limited so as to give effect to the fundamental rights as established by *Roe* and *Doe*; that is, not be burdensome on a woman's right to decide to abort a pregnancy. *By this we mean that in all probability nothing broader than general requirements as to the maintaining of sanitary facilities and general requirements as to meeting minimal building code standards would be permissible.* (Emphasis added.)

Thus, any regulation, even a general regulation, which burdens a woman's rights to choose to terminate her pregnancy during the first trimester would have to meet the compelling governmental interest requirement. In addition, under *Roe* and *Akron*, a regulation which burdens a woman's right to choose to terminate her pregnancy during the early second trimester must be "reasonably relate[d]" to the preservation and protection of maternal health. *Akron*, 462 U.S. at 430-431; *Roe*, 410 U.S. at 163.

In the present case, plaintiffs have overwhelmingly demonstrated the burden that the challenged statutory and regulatory scheme places on a woman's right to choose to terminate her pregnancy during the first and early second trimester. As noted in the previous discussion of irreparable injury, the scheme, as written *and as enforced*, increases the cost and decreases the availability of abortions. Also, the scheme may delay the effectuation of a woman's decision to abort.

Charles v. Carey, 627 F.2d 772, 777 (7th Cir. 1980), *app. after remand, sub nom. Charles v. Daley*, 749 F.2d 452 (7th Cir. 1984), instructs that once a plaintiff has shown that interference in the pregnancy termination decision is "sufficiently substantial and not de minimus," the State must show that there is compelling basis for the law and that the burden is not undue or unjustifiable. Here, plaintiffs have demonstrated that the challenged scheme substantially interferes with the pregnancy termination decision during the first and early second trimester.

Defendants, however, have failed to produce any evidence at all of a compelling or even rational basis for the challenged statutes and regulations. The defendants presented no evidence in their pleadings or at the hearing that the statutes and regulations are medically necessary.[23] Dr. Barton, the defendant's expert in obstetrics and gynecology, testified at the hearing that he was of the opinion that there is a medical necessity for some regulation by the state of outpatient abortion facilities, but Dr. Barton did not testify as to the medical necessity of any of the statutes or regulations here challenged. Also, Dr. Barton

agreed that there is no medical reason to single out abortion from other medically analogous procedures for different regulation. Defendants, at best, have shown that selected regulations, such as Regulation 205.730(b)(2)(a), which sets out the qualifications for counselors, are consistent with accepted medical practice. This is not equivalent to a showing of medical necessity.

Plaintiffs have established the burdensome nature of the scheme as a whole. Defendants have failed to demonstrate a compelling, or even a rational, basis for the statutory and regulatory scheme. Therefore, the court now finds that there is a reasonable likelihood that plaintiffs will succeed on the merits.

D. Harm To The Public Interest

In *Fox Valley*, 446 F. Supp. at 1075, the court found that the public's interest would not be disserved by the issuance of the preliminary injunction. The court reasoned that the public's interest lies in the enforcement of that which is mandated by the Constitution, and the Constitution mandated that the abortion regulation challenged in that case not be imposed. Likewise, in the present case, the Constitution mandates that the challenged statute and regulations not be applied to physicians who perform first trimester abortions or early second trimester DE abortions, or to the facilities in which these procedures are performed.

Of course, the public also has an interest in the preservation and protection of a patient's health. However, contrary to the argument of the State's Attorney at the preliminary injunction hearing, the injunction which the court now issues will not disserve this interest. At the hearing, the State's Attorney argued that, if the court issued the injunction prayed for, this would "open the door" to substandard abortion facilities in Illinois. Not so. The injunction here will not leave abortion clinics, such as the NIWC, free from all state regulation. On the contrary, such facilities will still have to meet the standards set

by local building codes. Also, physicians performing abortions are obligated to practice surgery with care and will still be subject to disciplinary action under the remaining subsections of section 16 of the MPA. The court therefore finds that the public interest will be served by the issuance of this preliminary injunction.

E. Scope of The Preliminary Injunction

Having found preliminary injunctive relief is appropriate in this case, the court now turns to the scope of the preliminary injunctive relief granted. In the above discussion dealing with the plaintiffs' demonstration of the likelihood of their success on the merits, the court found that defendants have failed to show a compelling need or even a rational basis for the burdensome statutory and regulatory scheme. Accordingly, the court preliminarily enjoins defendants from enforcing the challenged statutes and regulations against any plaintiffs who offer or perform first or early second trimester abortions.

V. Conclusion

For the reasons set forth above, the court grants plaintiffs' motion for certification of two plaintiff classes and one defendant class, with some modification. Also, the court grants plaintiffs' motion for preliminary injunction, and hereby enjoins defendants from enforcing the challenged statutes and regulations against any plaintiff offering, performing, or desiring to offer or perform a first or early second trimester abortion.

ENTER: /s/ JOHN A. NORDBERG
United States District Judge

Date: November 27, 1985

[1] The challenged statutes are not part of the explicitly separate Illinois "Abortion Laws," Ill. Rev. Stat. ch. 38, para. 81-21 to 81-35, 81-51 to 81-55, 81-61 to 81-70, the constitutionality of which has been challenged on several occasions. *See, e.g., Zbaraz v. Hartigan*, 763 F.2d 1532 (7th Cir. 1985); *Charles v. Carey*, 627 F.2d 772 (7th Cir. 1980), *appeal after remand sub nom. Charles v. Daley*, 749 F.2d 452 (7th Cir. 1984), *probable jurisdiction noted sub nom. Diamond v. Charles*, 105 S.Ct. 2356 (1985); *Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979); *Wynn v. Carey*, 582 F.2d 1375 (7th Cir. 1978).

Likewise, there have been previous challenges to the constitutionality of the statutes involved in this case. In *Village of Oak Lawn v. Marcowitz*, 86 Ill. 2d 406, 427 N.E.2d 36 (1981), the Illinois Supreme Court struck down a portion of a village ordinance, on equal protection and privacy grounds, which incorporated the ASTCA's definition of an Ambulatory Surgical Treatment Center ("ASTC"). Also in *Bickham v. Lashof*, No. 76 C 4564, slip op. (N.D. Ill. Jan. 28, 1981), the court denied defendants' motion to dismiss the allegations in plaintiff's complaint that the ASTCA and MPA are unconstitutional. However, this case, which dealt with some of the exact issues presented here, was apparently dismissed for want of prosecution without a decision on the merits.

[2] Mr. Triemari, a Consulting Engineer and an expert in plumbing, heating and air conditioning, testified at the injunction hearing that the ASTC physical plant regulations are comparable, or generally equivalent, to those in the Illinois Hospital Licensing Act, Ill.Rev.Stat. ch. 111½, para. 142, *et seq.*, and the Chicago Hospital Ordinance. He also testified that many of the requirements, such as those dealing with air flow, are not required of physicians' offices.

[3] Raymond Passeri, the Chief of the Division of Facilities Development at the IDPH and the Executive Secretary of the Board, testified at the hearing that the HFPA was enacted in part because of the concern that allowing an unlimited number of health care facilities to be constructed would not fill a "need," but would instead waste the Illinois taxpayers' money because of the cost-plus disbursement arrangement. This arrangement is no longer in effect, and, certainly, abortion facilities do not utilize public funds for construction or renovation; therefore, the certificate of need procedure seems particularly inappropriate as applied to abortion facilities.

[4] Dr. Ragsdale presented the NIWC's complication statistics at the hearing. According to Dr. Ragsdale, approximately 9 women per 40,000 require immediate hospitalization after having an abortion at the NIWC, no deaths have resulted from abortions at the NIWC, and 10 to 15 women per 40,000 develop complications within a few days after an abortion at the NIWC, such as a fever from infection. These extremely low complication rates attest to Dr. Ragsdale's skill and experience as an abortion provider. Both Margaret Moe, an expert in the area of women's health care and family planning, and Dr. Hern, an expert on abortion practice, testified at the hearing that, in their opinion, Dr. Ragsdale is an extremely skilled and careful abortion provider. Indeed, even Dr. Barton, the defendants' expert on obstetrics and gynecology, testified that he has "some certainty" that the hospital in which he works, Illinois Masonic Medical Center, has referred patients to Dr. Ragsdale for abortions.

[5] There are currently 44 ASTCs in Illinois. Approximately half of these provide abortion services.

[6] In the preliminary injunction hearing, defendant Richard M. Daley, through his attorney, did point out on cross examination of Margaret Moe that Margaret Moe had personally worked with physicians in only Cook and Kane Counties.

[7] Defendants contend in their Response to the Motion for Class Certification that Dr. Ragsdale's claims are not typical of those of the proposed class because the NIWC has been a licensed ASTC since 1973; therefore, "Dr. Ragsdale is challenging the constitutionality of the statutes and regulations through which he has benefitted for more than ten years." Defendants' Response, p. 3. The court finds this argument without merit. Defendants do not articulate what "benefit" Dr. Ragsdale receives under the challenged statutes and regulations. Neither do defendants recognize that other members of the proposed class may also have operated licensed ASTCs for a number of years. It is axiomatic that those to whom statutes and regulations apply may challenge the constitutionality of such statutes and regulations despite a period of compliance. *See, e.g., Friendship Medical Center, Ltd. v. Chicago Board of Health*, 505 F.2d 1141, 1146 (7th Cir. 1974), *cert. denied*, 420 U.S. 955 (1975). Indeed, under the standing requirements of Article III of the United States Constitution, as interpreted by the courts, parties against whom statutes and regulations directly operate may be the "best" plaintiffs for a constitutional challenge, given their concrete personal stake in the outcome of the litigation.

[8] Defendants contend that the declaratory and injunctive relief plaintiffs request can be granted to all class members without certifying a class; therefore, plaintiffs' motion should be denied. In the Seventh Circuit, however, if a class meets the prerequisites of Rule 23, a court may not deny class certification on the ground of lack of "need." *Brown v. Scott*, 602 F.2d 791, 795 (7th Cir. 1979), *aff'd sub nom. Carey v. Brown*, 447 U.S. 455 (1980); *Vergara*, 581 F.2d at 1284.

[9] In *Friendship*, the challenged regulations empowered the city to deny authorization to those seeking to operate abortion facilities and to order the closing of a facility not in compliance with its regulations. According to the Seventh Circuit, "Surely, those subject to such deprivations through the use of governmental power have a sufficient interest to maintain this type of action. [citations omitted]" *Friendship*, 505 F.2d at 1146.

[10] Based on the preliminary injunction proceedings, it is clear that Dr. Ragsdale and Margaret Moe will adequately represent the interests of this proposed plaintiff class. In both the pleadings and the hearing on the preliminary injunction motion, the named plaintiffs, through their attorneys, focused almost exclusively on the alleged unconstitutional burden that these statutes and regulations place on the right of Illinois women to decide whether to obtain an abortion.

[11] The *Thillens* court also discussed the problems inherent in certifying both plaintiff and defendant classes in the same action. *Thillens*, 97 F.R.D. at 675-76. The court noted that courts are often reluctant to certify a defendant class when the action is brought by a plaintiff class because of the concern that each plaintiff member has not been injured by each defendant member. However, according to the court, as it interpreted *In re Gap Stores Securities Litigation*, 79 F.R.D. 283 (N.D. Cal. 1978), the requirement that each named plaintiff have a claim against each defendant may be waived where the defendant members are related by a conspiracy or "juridical link." The *Thillens* court went on to define a "juridical link" as "some legal relationship which relates all defendants in a way such that single resolution of the dispute is preferred to a multiplicity of similar actions. [citations omitted]"

There is clearly a "juridical link" between the Illinois State's Attorneys here. Under Ill. Rev. Stat. ch. 14, para. 5, each and every State's Attorney is charged with the duty of prosecuting all civil and criminal actions in which the people of the state or county may be concerned. Also, under section 14 of the HFPA, which deals with violations, the State's Attorneys are specifically charged with the duty of representing the people of Illinois in proceedings under that section. As all State's Attorneys are charged under the same statutes with the duty to take uniform enforcement action with respect to plaintiffs, the court therefore finds that the State's Attorneys are related in a way such that single resolution of the dispute is preferred to a multiplicity of similar actions.

[12] Some of the State's Attorneys may contend, as Mr. Daley did in his Answer, that the plaintiffs have not stated a cause of

action specifically against them. This "affirmative defense" in Mr. Daley's answer apparently rested on the fact that Dr. Ragsdale's clinic was not in Cook County; therefore, Mr. Daley could not prosecute under the ASTCA or HFPA, and Dr. Ragsdale did not "state a cause of action" against Mr. Daley. Dr. Ragsdale is not the only plaintiff, however. Margaret Moe, another named plaintiff, owns and operates a medical facility in Cook County, and she clearly has stated a cause of action against Mr. Daley.

Given the certification of the two plaintiff classes in this order, it is expected that few, if any, State's Attorneys will be able to raise this defense. Accordingly, the court finds that the possibility that any one State's Attorney will raise this defense does not substantially affect the "typical" nature of the named defendants' defenses. *See Research Corp.*, 301 F. Supp. at 499.

[13] Dr. Ragsdale testified at the preliminary injunction hearing that his current fee for an abortion is approximately $250. Dr. Ragsdale estimated that if he were to move his practice to a facility similar to his current facility, which does not fully comply with the ASTCA regulations, he would have to increase by $22.45 the fee per patient over the next two years to cover his costs. Plaintiffs' Exhibit No. 17. Relocating his practice to a building in total compliance with the regulations, on the other hand, would add another $25.21 to the increase, making the total increase in fee per patient $47.66. Plaintiffs' Exhibit No. 18.

[14] Margaret Moe also testified that she telephoned the IDPH on November 18, 1985, to find out whether the IDPH still requires all abortion facilities to be licensed. At that time, an employee in the division of the ASTC licensing informed her that the IDPH was not currently requiring licenses for abortion facilities, but the IDPH "recommended" licensure. Margaret Moe had never before been informed that the IDPH was no longer requiring abortion facilities to obtain ASTC licenses. The court notes that it was not clear from this testimony whether the IDPH no longer requires ASTC licenses even for facilities "primarily devoted" to the performance of abortions. The testimony of Mary Lloyd Lowe, Deputy Chief Counsel for the Illinois Department of Public Health, and Defendants' Exhibit No. 2, an IDPH internal memorandum written by Michael Anderson, indicate that the IDPH still requires licensure for those facilities "primarily devoted" to providing abortion services.

[15] Dr. Ragsdale testified at the hearing that it took him five full working days to complete the HFPA application for a certificate of need.

[16] At the preliminary injunction hearing, Mary Lloyd Lowe testified that the IDPH also releases ASTC license applications, when

requested, pursuant to the Illinois Freedom of Information Act. Under the ASTCA and its regulations, such applications must also include a statement of ownership and a description of the services to be provided. ASTCA § 7(a), 77 Ill. Admin. Code § 205.120. The ASTC license application is also lengthy and detailed, as demonstrated by Plaintiffs' Exhibit No. 21, Dr. Ragsdale's 1985 ASTC license application.

[17] Dr. Ragsdale testified that the ASTCA requirements that an abortion facility be separately licensed and maintain an "identifiably separate" facility also subject abortion providers and their patients to threats and harrassment.

[18] *See* Plaintiffs' Exhibit No. 11, "Certificate of Need Investigative Staff Report to the Comprehensive Health Planning of Northern Illinois Regional Board and Project Review Committee."

[19] Margaret Moe testified at the hearing that approximately 90% of the patients at her Elgin, Illinois clinic have no means of transportation, and approximately 50% of the patients at her Palatine, Illinois clinic have no means of transportation.

[20] According to Margaret Moe, one of the greatest concerns of the patients at her clinics who desire to have an abortion is that Margaret Moe be able to refer them to a physician she knows is competent. Were Margaret Moe able to offer abortion services at her own clinics, she could, of course, assure her patients of the competency of the performing physicians.

[21] Dr. Ragsdale and Dr. Hern both testified at the hearing of the safety of the Dilation and Evacuation procedure, which has recently become the method most often utilized for abortions in the early part of the second trimester. In addition, defendants tendered as their Exhibit No. 6 the Standards for Obstetric-Gynecological Services, developed by the American College of Obstetricians and Gynecologists ("ACOG Standards") (6th ed. 1985). According to the ACOG Standards, and as noted by the *Akron* Court, uncomplicated abortions, up to 14 weeks from the last menstrual period, may be performed in a physician's office or an outpatient clinic. ACOG Standards, p. 60.

[22] In *Abortion Coalition v. Michigan Department of Public Health*, 426 F. Supp. 471, 474-476 (E.D. Mich. 1977), the court, in dicta, indicated that general regulations imposed upon medically analogous procedures are not invalid as applied to first trimester abortions. However, at the same time, the court held certain provisions of the "general" statute to be unconstitutional as applied to first trimester abortions. Moreover, in *Birth Control Centers, Inc. v. Reizen*, 508 F. Supp. 1366 (E.D. Mich. 1981), *aff'd in part, vac. in part*, 743 F.2d 352 (6th Cir. 1984), the court struck down

still more sections of the "general" Michigan Public Health Code, which required all freestanding surgical outpatient facilities to have transfer agreements with hospitals and to have six-foot corridors.

[23] Plaintiffs, on the other hand, presented testimony by Dr. Ragsdale and Dr. Hern that the regulations are not only medically unnecessary, but some of the regulations, particularly those requiring ASTCs to be hospital-like facilities, may be medically detrimental, for women often find it psychologically reassuring when they are able to effectuate their decision to abort in a comfortable, more personalized atmosphere.

Defendants' difficulty in providing evidence of the medical necessity of the burdensome statutes and regulations challenged here is understandable, given that other courts have already found that similar or identical provisions burden a woman's right to choose to terminate her pregnancy without furthering a compelling state interest. *See Arnold v. Sendak*, 416 F. Supp. 22 (S.D. Ind. 1976) (finding unconstitutional an Indiana statute requiring all abortions to be performed in hospitals or licensed health care facilities), *aff'd mem.*, 429 U.S. 968 (1976); *Village of Oak Lawn v. Marcowitz*, 86 Ill. 2d 406, 427 N.E.2d 36 (1981) (finding the portion of the definition of an ASTC including "any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose" to be unconstitutional).

APPENDIX H

NOTICE OF APPEAL

[Filed November 7, 1988]

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 85-3242

RICHARD M. RAGSDALE, M.D., et al.,

Plaintiffs-Appellees,

vs.

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, et al.,

Defendants-Appellants.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division
No. 85 C 6011—John Nordberg, Judge Presiding

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

Notice is hereby given that defendants-appellants Bernard J. Turnock, Director of the Illinois Department of Public Health; Neil F. Hartigan, Attorney General of Illinois; and Stephen F. Selcke, Director of the Illinois Department of

Professional Regulation,* hereby appeal to the Supreme Court of the United States from judgment of the United States Court of Appeals for the Seventh Circuit affirming an order of the United States District Court, Northern District of Illinois, Eastern Division, and holding unconstitutional and enjoining enforcement of the Ambulatory Surgical Treatment Center Act and the rules and regulations promulgated thereunder; the Health Facilities Planning Act; and par. 4433(1)(a)-(e) of the Illinois Medical Practice Act to the extent any person or facility offers or performs, or desires to offer or perform first and/or early second trimester abortions or other abortion-related gynecological procedures. The judgment was entered on March 10, 1988. On August 12, 1988 the appellants' petition for rehearing and suggestion for rehearing en banc was denied.

This appeal is taken pursuant to 28 U.S.C. Section 1254(a).

Respectfully submitted,

NEIL F. HARTIGAN
Attorney General of Illinois

BY: /s/ KATHLEEN KREISEL FLAHAVEN
Assistant Attorney General
General Law Division
100 West Randolph Street
13th Floor
Chicago, Illinois 60601

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* Successor in public office to Gary L. Clayton, Director of the Illinois Department of Registration and Education.

AFFIDAVIT OF SERVICE

I hereby aver that a true and correct copy of the foregoing was served upon all parties required to be served at the listed addresses by depositing same in the United States mail chute located at 100 West Randolph Street, Chicago, Illinois 60601 on the 7th day of November, 1988 with proper postage prepaid.

Alan S. Gilbert
Lorie A. Chaiten
Sonnenschein, Carlin,
Nath & Rosenthal
8000 Sears Tower
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Colleen K. Connell
The Roger Baldwin
Foundation of ACLU
20 East Jackson Boulevard
Suite 1600
Chicago, Illinois 60604

Randolph T. Kemmer
Assistant State's Attorney
500 Richard J. Daley Center
Chicago, Illinois 60602

/s/ KATHLEEN KREISEL FLAHAVEN

SUBSCRIBED AND SWORN TO
BEFORE ME THIS 7th DAY
OF NOVEMBER, 1988.

/s/ JANET M. VOLDRICH
Notary Public

APPENDIX I

Ambulatory Surgical Treatment Center Act, 111½ Ill. Rev. Stat. ¶¶ 157-8.1, *et seq.*

AMBULATORY SURGICAL TREATMENT CENTER ACT

AN ACT relating to the inspection, licensing and regulation of ambulatory surgical treatment centers. P.A. 78-227, approved and eff. July 19, 1973.

157-8.1. Short title

§ 1. This act may be cited as the Ambulatory Surgical Treatment Center Act.

157-8.2. Declaration of public policy—Purpose

§ 2. It is declared to be the public policy that the State has a legitimate interest in assuring that all medical procedures, including abortions, are performed under circumstances that insure maximum safety. Therefore, the purpose of this Act is to provide for the better protection of the public health through the development, establishment, and enforcement of standards (1) for the care of individuals in ambulatory surgical treatment centers, and (2) for the construction, maintenance and operation of ambulatory surgical treatment centers, which, in light of advancing knowledge, will promote safe and adequate treatment of such individuals in ambulatory surgical treatment centers.

157-8.3. Definitions

§ 3. As used in this Act, unless the context otherwise requires, the following words and phrases shall have the meanings ascribed to them:

(A) "Ambulatory surgical treatment center" means any institution, place or building devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures or any facility in which a medical or

surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose. Such facility shall not provide beds or other accommodations for the overnight stay of patients. Individual patients shall be discharged in an ambulatory condition without danger to the continued well being of the patients or shall be transferred to a hospital.

The term "ambulatory surgical treatment center" does not include (1) any institution, place, building or agency required to be licensed pursuant to the "Hospital Licensing Act", approved July 1, 1953, as amended.[1]

(2) any person or institution required to be licensed pursuant to the "Nursing Home Care Reform Act of 1979" approved August 23, 1979, as amended;[2]

(3) hospitals or ambulatory surgical treatment centers maintained by the State of any department or agency thereof, where such department or agency has authority under law to establish and enforce standards for the hospitals or ambulatory surgical treatment centers under its management and control;

(4) hospitals or ambulatory surgical treatment centers maintained by the Federal Government or agencies thereof; or

(5) any place, agency, clinic, or practice, public or private, whether organized for profit or not, devoted exclusively to the performance of dental or oral surgical procedures.

(B) "Person" means any individual, firm, partnership, corporation, company, association, or joint stock association, or the legal successor thereof.

(C) "Department" means the Department of Public Health of the State of Illinois.

(D) "Director" means the Director of the Department of Public Health of the State of Illinois.

(E) "Physician" means a person licenced to practice medicine in all of its branches in the State of Illinois.

(F) "Dentist" means a person licensed to practice dentistry under the "Illinois Dental Practice Act."[3]

(G) "Podiatrist" means a person licensed to practice podiatry under "An Act to regulate the practice of podiatry in the State of Illinois", approved April 26, 1917, as amended.[4]

Amended by P.A. 83-333, § 60, eff. Sept. 14, 1983.

[1] Paragraph 142 et seq. of this chapter.

[2] Paragraph 4151-101 et seq. of this chapter.

[3] Chapter 111, ¶ 2201 et seq.

[4] Chapter 111, ¶ 4901 et seq.

157-8.4. Necessity of license—Municipal regulation

§ 4. No person shall open, conduct or maintain an ambulatory surgical treatment center without first obtaining a license from the Department.

Nothing in this Act shall be construed to impair or abridge the power of municipalities to license and regulate ambulatory surgical treatment centers, provided that the municipal ordinance requires compliance with at least the minimum requirements developed by the Department pursuant to this Act.

The Administrative Review Law, as heretofore or hereafter amended,[1] shall be applicable to the judicial review of final administrative decisions of the regulatory agency of the municipality. Any municipality having an ordinance licensing and regulating ambulatory surgical treatment centers which provides for minimum standards and regulations which meet at least the minimum requirements established pursuant to this Act shall make such periodic reports to the Department as the Department may deem necessary. This report shall include a list of ambulatory surgical treatment centers meeting standards substantially equivalent to those promulgated by the Department under this Act. The Department may issue a license to such ambulatory surgical treatment centers based upon such reports or the Department may conduct investigations or

inspections to determine whether a license should be issued to these ambulatory surgical treatment centers.

Amended by P.A. 82-783, Art. XI, § 201, eff. July 13, 1982.

[1] Chapter 110, ¶ 3-101 et seq.

157-8.5. Application for license

§ 5. An application for a license to operate an ambulatory surgical treatment center shall be made to the Department upon forms provided by it and shall contain such information as the Department reasonably requires, which may include affirmative evidence of ability to comply with the provisions of this Act and the standards, rules and regulations, promulgated by virtue thereof.

All applications required under this Section shall be signed by the applicant, verified, and accompanied by a license fee of $500.

Amended by P.A. 81-224, § 1, eff. Jan. 1, 1980.

157-8.6. Issuance of license—Requirements—Renewal of license—Provisional licenses

§ 6. Upon receipt of an application for a license, the Director may deny the application for any of the following reasons:

(1) Conviction of the applicant, or if the applicant is a firm, partnership or association, of any of its members, or if a corporation, of any of its officers or directors, or of the person designated to manage or supervise the facility, of a felony, or of 2 or more misdemeanors involving moral turpitude, as shown by a certified copy of the record of the court of conviction, or, in the case of the conviction of a misdemeanor by a court not of record, as shown by other evidence, if the Director determines, after investigation, that such person has not been sufficiently rehabilitated to warrant the public trust; or other satisfactory evidence that the moral character of the applicant, or manager, or supervisor of the facility is not reputable;

(2) The licensure status or record of the applicant, or if the applicant is a firm, partnership or association, of any of its members, or if a corporation, of any of its officers or directors, or of the person designated to manage or supervise the facility, from any other state where the applicant has done business in a similar capacity indicates that granting a license to the applicant would be detrimental to the interests of the public; or

(3) The applicant has insufficient financial or other resources to operate and conduct the facility in accordance with the requirements of this Act and the minimum standards, rules and regulations promulgated thereunder.

The Director shall only issue a license if he finds that the applicant facility complies with this Act and the rules, regulations and standards promulgated pursuant thereto and:

(a) is under the medical supervision of one or more physicians;

(b) permits a surgical procedure to be performed only by a physician, podiatrist or dentist who at the time is privileged to have his patients admitted by himself or an associated physician and is himself privileged to perform surgical procedures in at least one Illinois hospital; and

(c) maintains adequate medical records for each patient.

A license, unless sooner suspended or revoked, shall be renewable annually upon approval by the Department and payment of a license fee of $300. Each license shall be issued only for the premises and persons named in the application and shall not be transferable or assignable. The licenses shall be posted in a conspicuous place on the licensed premises. A placard or registry of all physicians on staff in the facility shall be centrally located and available for inspection to any interested person. The Department may, either before or after the issuance of a license, request the cooperation of the State Fire Marshal. The report and recommendations of this agency shall be in writing and shall state with particularity its findings with

respect to compliance or noncompliance with such minimum standards, rules and regulations.

The Director may issue a provisional license to any ambulatory surgical treatment center which does not substantially comply with the provisions of this Act and the standards, rules and regulations promulgated by virtue thereof provided that he finds that such ambulatory surgical treatment center will undertake changes and corrections which upon completion will render the ambulatory surgical treatment center in substantial compliance with the provisions of this Act, and the standards, rules and regulations adopted hereunder, and provided that the health and safety of the patients of the ambulatory surgical treatment center will be protected during the period for which such provisional license is issued. The Director shall advise the licensee of the conditions under which such provisional license is issued, including the manner in which the facilities fail to comply with the provisions of the Act, standards, rules and regulations, and the time within which the changes and corrections necessary for such ambulatory surgical treatment center to substantially comply with this Act, and the standards, rules and regulations of the Department relating thereto shall be completed.

Amended by P.A. 81-224, § 1, eff. Jan. 1, 1980.

157-8.6-1. Abortions—Licensed physicians

§ 6.1. Notwithstanding any other provision of this Act, any corporation operating an Ambulatory Surgical Treatment Center devoted primarily to providing facilities for abortion must have a physician, who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the Center, on the board of directors as a condition to licensure of the Center.

Added by P.A. 81-771, § 1, eff. Jan. 1, 1980.

157-8.7. Denial, suspension and revocation of license—Notice—Hearings—Subpoenas—Depositions

§ 7. The Director after notice and opportunity for hearing to the applicant or licensee may deny, suspend, or revoke a license to open, conduct and maintain an ambulatory surgical treatment center in any case in which he or she finds that there has been a substantial failure to comply with the provisions of this Act or the standards, rules and regulations established by virtue thereof.

Such notice shall be effected by registered mail or by personal service setting forth the particular reasons for the proposed action and fixing a date, not less than 15 days from the date of such mailing or service, at which time the applicant or licensee shall be given an opportunity for a hearing.

A copy of the notice shall be displayed in a conspicuous place adjacent to the license required to be displayed under Section 6 of this Act[1] until such time as the Department renders its final administrative order. At the end of each fiscal quarter the Department shall prepare and publish a report regarding the status or final disposition of its actions against licensees or applicants that have been served with notice regarding a contemplated denial, a refusal to renew or revocation of a license by the Department. The report shall identify the facility and the licensee or applicant that are the subject of contemplated action and summarize the facts and charges that constitute the grounds for such action. The reports shall be conveyed to the Governor and the General Assembly and shall be made available to the general public free of charge. Copies of such reports shall be available for distribution through local health departments and regional and sub-regional offices of the Department.

The hearing shall be conducted by the Director or by an individual designated in writing by the Director as Hearing Officer to conduct the hearing. On the basis of any such hearing, or upon default of the applicant or licensee, the Director shall make a determination specify-

ing his or her findings and conclusions. A copy of such determination shall be sent by registered mail or served personally upon the applicant or licensee.

The procedure governing hearings authorized by this Section shall be in accordance with rules promulgated by the Department. A full and complete record shall be kept of all proceedings, including the notice of hearing, complaint, and all other documents in the nature of pleadings, written motions filed in the proceedings, and the report and orders of the Director and Hearing Officer. All testimony shall be reported but need not be transcribed unless the decision is sought to be reviewed pursuant to the Administrative Review Law.[2] A copy or copies of the transcript may be obtained by any interested party on payment of the cost of preparing such copy or copies.

The Director or Hearing Officer, shall upon his or her own motion, or on the written request of any party to the proceeding, issue subpoenas requiring the attendance and the giving of testimony by witnesses, and subpoenas duces tecum requiring the production of books, papers, records or memoranda. All subpoenas and subpoenas duces tecum issued under the terms of this Act may be served by any person of legal age. The fees of witnesses for attendance and travel shall be the same as the fees of witnesses before the Circuit Court of this State, such fees to be paid when the witness is excused from further attendance. When the witness is subpoenaed at the instance of the Director or Hearing Officer, such fees shall be paid in the same manner as other expenses of the Department, and when the witness is subpoenaed at the instance of any other party to any such proceeding the Department may require that the cost of service of the subpoena or subpoena duces tecum and the fee of the witness be borne by the party at whose instance the witness was summoned. In such case, the Department in its discretion, may require a deposit to cover the cost of such service and witness fees. A subpoena or subpoena duces tecum so issued as above stated shall be served in the same manner as a subpoena issued by a circuit court.

Any circuit court of this State, upon the application of the Director, or upon the application of any other party to the proceeding, may, in its or his or her discretion, compel the attendance of witnesses, the production of books, papers, records or memoranda and the giving of testimony before the Director or Hearing Officer conducting an investigation or holding a hearing authorized by this Act, by an attachment for contempt or otherwise, in the same manner as production of evidence may be compelled before the court.

The Director or Hearing Officer, or any party in an investigation or hearing before the Department, may cause the depositions of witnesses within the State to be taken in the manner prescribed by law for like depositions in civil actions in courts of this State, and to that end compel the attendance of witnesses and the production of books, papers, records, or memoranda.

Amended by P.A. 82-783, Art. XI, § 201, eff. July 13, 1982; P.A. 83-334, § 87, eff. Sept. 14, 1983; P.A. 83-345, § 67, eff. Sept. 14, 1983.

[1] Paragraph 157-8.6 of this chapter.

[2] Chapter 110, ¶ 3-101 et seq.

P.A. 83-334, in the first paragraph, inserted "or she"; in the second paragraph, substituted "15" for "fifteen"; in the fourth paragraph, inserted "or her"; in the sixth paragraph, inserted "or her", substituted "above stated" for "aforesaid", and, at the end of the sixth paragraph, substituted "by a circuit court" for "out of a court of record"; in the seventh paragraph, following "State", deleted "or any judge thereof, either in term time or vacation", and, also in the seventh paragraph, inserted "or her", and substituted "the" for "said" the last place it appears in the seventh paragraph.

P.A. 83-345, in the second paragraph, substituted "15" for "fifteen"; in the sixth paragraph, inserted "or her", and substituted "legal" for "full"; in the last sentence of the sixth paragraph, inserted "so" and "circuit", and, following "issued", deleted "as aforesaid", and, following "court", deleted "of record"; in the seventh paragraph, following "State", deleted "or any judge thereof, either in term time or vacation"; in the seventh paragraph, preceding "discretion", deleted "or his"; and substituted "the" for "said" the last place it appears in the seventh paragraph.

Final legislative action, 83rd General Assembly:

P.A. 83-334—June 20, 1983

P.A. 83-345—June 20, 1983

See Ill.Rev.Stat. ch. 1, ¶ 1105 as to the effect of (1) more than one amendment of a section at the same session of the General Assembly or (2) two or more acts relating to the same subject matter enacted by the same General Assembly.

157-8.7a. Statement or ownership

§ 7a. (a) As a condition of the issuance or renewal of the license of any ambulatory surgical treatment center, the applicant shall file a statement of ownership. The applicant shall agree to update the information required in the statement of ownership every 6 months from the initial date of filing.

(b) The statement of ownership shall include the following:

(1) The name, telephone number and occupation of every person who has entered into a contract to manage or operate or who owns or controls, directly or indirectly, any of the shares of stock of, or any other financial interest in, the facility which is the subject of the application or license, and the percentage of such interest; and

(2) The address of any facility, wherever located, any financial interest in which is owned or controlled, directly or indirectly, by the applicant, if the facility is required to be licensed if it were located in this State.

Added by P.A. 81-224, § 1, eff. Jan. 1, 1980.

157-8.7b. Financial statements

§ 7b. (a) Each licensee shall file an attested financial statement with the Department by July 1, 1980 and at times thereafter as required. An audited financial statement may be required of a particular facility, if the Director determines that additional information is needed.

(b) No public funds shall be expended for the care or treatment of any patient in an ambulatory surgical treatment center which has failed to file the financial statement required by this Section, and no public funds shall be paid to or on behalf of a facility which has failed to file a statement.

(c) The Director shall promulgate regulations for the filing of financial statements, and shall provide in these regulations for forms, information required, intervals and dates of filing, and such other provisions as he may deem necessary. Regulations shall be published in sufficient time to permit those licensees who must first file financial statements time in which to do so.

(d) The Director shall seek the advice and comments of other State and Federal agencies which require the submission of financial data from facilities licensed under this Act and shall incorporate the information requirements of these agencies into the forms it adopts or issues under this Act and shall otherwise coordinate its regulations with the requirements of these agencies so as to impose the least possible burden on licensees. No other State agency may require submission of financial data except as expressly authorized by law or as necessary to meet requirements of federal law or regulation. Information obtained under this Section shall be made available, upon request, by the Department to any other State agency or legislative commission to which such information is necessary for investigations or to execute the intent of State or Federal law or regulation.

Added by P.A. 81-224, § 1, eff. Jan. 1, 1980.

157-8.8. Construction, alterations or additions to treatment centers—Approval by Department

§ 8. Before commencing construction of new facilities or specified types of alteration or additions to an existing ambulatory surgical treatment center, architectural drawings and specifications therefor shall be submitted to the Department for review and approval. Final approval of

the drawings and specifications for compliance with design and construction standards shall be obtained from the Department before the alteration, addition, or new construction is begun.

157-8.9. Inspections and investigations—Confidentiality of information

§ 9. The Department shall make or cause to be made such inspections and investigations as it deems necessary but in no case less than 4 inspections of any licensed facility in a fiscal year. Information received by the Department through filed reports, inspection, or as otherwise authorized under this Act shall not be disclosed publicly in such manner as to identify individual patients, except to another State agency for purposes of investigation of professional or business practices in a licensed ambulatory surgical treatment center, which State agency shall not disclose such individual patient information publicly.

Every facility licensed under this Act and any premises proposed to be conducted as a facility by an applicant for a license shall be open at all reasonable times to an inspection authorized in writing by the Director. No notice need be given to any person prior to any inspection.

Amended by P.A. 81-1509, Art. I, § 69, eff. Sept. 26, 1980.

Article I of P.A. 81-1509 was the 1980 Combining Revisory Act, which resolved multiple actions of the 81st General Assembly through P.A. 81-1224.

157-8.9a. Closings—Orders—Hearings and reinspections

§ 9a. Whenever an inspection of any ambulatory surgical treatment center discloses that the continued operation of such facility constitutes an imminent and serious menace to the health or safety of the patients thereof, or in the event of a conviction of a licensee under Section 12 of this Act,[1] the inspector is authorized to immediately close such facility. Once the facility has been closed, the personnel employed there shall cease any activity re-

lated to the patients, unless continued treatment of any given patient is necessary to protect his or her health or life. A written order setting forth the grounds on which any action under this Section is based shall be served on the licensee within 24 hours after such action is taken. Any licensee whose ambulatory surgical treatment center has been closed may, within 10 days thereafter, by written notice, request that the Director conduct a hearing and a reinspection under the provisions of this Act. If a subsequent inspection discloses that the violations of this Act or rules, regulations or standards have been abated, the Director shall cancel the order of closing and permit patients to be treated therein. The remedies provided in this Section are in addition to and not exclusive of any other remedy provided by law.

Added by P.A. 81-224, § 1, eff. Jan. 1, 1980.

[1] Paragraph 157-8.12 of this chapter.

157-8.9b. Complaints—Ambulatory surgical treatment center

§ 9b. The Department shall establish by rule a procedure for receiving and investigating complaints regarding any ambulatory surgical treatment center or any physician practicing in any such faciiity.

Added by P.A. 81-224, § 1, eff. Jan. 1, 1980.

157-8.10. Standards, rules and regulations—Construction—Personnel—Equipment—Facilities, programs and services

§ 10. The Department shall prescribe and publish minimum standards, rules and regulations necessary to implement the provisions of this Act which shall include, but not be limited to:

(a) construction of the facility including, but not limited to, plumbing, heating, lighting, and ventilation which shall ensure the health, safety, comfort and privacy of patients and protection from fire hazard;

(b) number and qualifications of all personnel, including administrative and nursing personnel, having reponsibility for any part of the care provided to the patients;

(c) equipment essential to the health, welfare and safety of the patients; and

(d) facilities, programs and services to be provided in connection with the care of patients in ambulatory surgical treatment centers.

157-8.10a. Administrative Procedure Act—Application

§ 10a. The provisions of "The Illinois Administrative Procedure Act", approved September 22, 1975,[1] are hereby expressly adopted and shall apply to all administrative rules and procedures of the Department of Public Health under this Act, except that in case of conflict between "The Illinois Administrative Procedure Act" and this Act the provisions of this Act shall control, and except that Section 5 of the Illinois Administrative Procedure Act[2] relating to procedures for rule-making does not apply to the adoption of any rule required by federal law in connection with which the Department is precluded by law from exercising any discretion.

Added by P.A. 79-1347, § 17, eff. July 1, 1977.

[1] Chapter 127, ¶ 1001 et seq.

[2] Chapter 127, ¶ 1005.

157-8.11. Review under Administrative Review Law

§ 11. Whenever the Department refuses to grant, or revokes or suspends a license to open, conduct or maintain an ambulatory surgical treatment center, the applicant or licensee may have such decision judicially reviewed. The provisions of the Administrative Review Law[1] and the rules adopted pursuant thereto shall apply to and govern all proceedings for the judicial review of final administrative decisions of the Department hereunder. The term "administrative decisions" is defined as in Section 3-101 of the Code of Civil Procedure.[2]

Amended by P.A. 82-783, Art. XI, § 201, eff. July 13, 1982.

[1] Chapter 110, ¶ 3-101 et seq.

[2] Chapter 110, ¶ 3-101.

157-8.12. Violations—Penalties

§ 12. Any person opening, conducting or maintaining an ambulatory surgical treatment center without a license issued pursuant to this Act shall be guilty of a business offense punishable by a fine of $10,000 and each day's violation shall constitute a separate offense. Any person opening, conducting or maintaining an ambulatory surgical treatment center who violates any other provision of this Act shall be guilty of a business offense punishable by a fine of not more than $10,000.

Amended by P.A. 81-224, § 1, eff. Jan. 1, 1980.

157-8.13. Violation of Act or rules and regulations as nuisance—Injunction

§ 13. The operation or maintenance of an ambulatory surgical treatment center in violation of this Act or of the Rules and Regulations promulgated by the Department is declared a public nuisance inimical to the public welfare. The Director of the Department, in the name of the People of the State, through the Attorney General or the State's Attorney of the county in which the violation occurs, may, in addition to other remedies herein provided, bring action for an injunction to restrain such violation or to enjoin the future operation or maintenance of any such ambulatory surgical treatment center.

157-8.14. Licensing Board—Appointment—Qualifications—Term—Vacancy—Expenses—Meetings—Duties

§ 14. The Governor shall appoint an Ambulatory Surgical Treatment Center Licensing Board composed of 12 persons. Four members shall be practicing physicians; one member shall be a practicing podiatrist; one member shall

be a dentist who has been licensed to perform oral surgery; one member shall be an Illinois registered professional nurse who is employed in an ambulatory surgical treatment center; one member shall be a person actively engaged in the supervision or administration of a health facility; and 4 members shall represent the general public and shall have no personal economic interest in any institution, place or building licensed pursuant to this Act. In making Board appointments, the Governor shall give consideration to recommendations made through the Director by appropriate professional organizations.

Each member shall hold office for a term of 3 years and the terms of office of the members first taking office shall expire, as designated at the time of appointments, 3 at the end of the first year, 3 at the end of the second year, and 6 at the end of the third year, after the date of appointment. The term of office of each original appointee shall commence October 1, 1973; and the term of office of each successor shall commence on October 1 of the year in which his predecessor's term expires. Any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term. Board members, while serving on business of the Board shall receive actual and necessary travel and subsistence expenses while so serving away from their places of residence. The Board shall meet as frequently as the Director deems necessary, but not less than once a year. Upon request of 3 or more members, the Director shall call a meeting of the Board.

The Board shall advise and consult with the Department in the administration of this Act, provided that no rule, regulation or standard shall be adopted by the Department concerning the operation of ambulatory surgical treatment centers licensed under this Act which has not had prior approval of the Ambulatory Surgical Treatment Center Licensing Board.

Amended by P.A. 79-339, § 1, eff. Oct. 1, 1975.

157-8.15. Severability of invalid provisions

§ 15. If any provision of this Act or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions of application of the Act which can be given effect without the invalid provision or application, and to this end the provisions of the Act are declared to be severable.

157-8.16. Effective date

§ 16. This Act shall take effect upon its becoming a law.

APPENDIX J

Health Facilities Planning Act, 111½ Ill. Rev. Stat. ¶¶ 1151, *et seq.*

ILLINOIS HEALTH FACILITIES PLANNING ACT

AN ACT to provide for the planning of Illinois health facilities. P.A. 78-1156, approved and eff. Aug. 27, 1974.

1151. Short title

§ 1. This Act shall be known and may be cited as the Illinois Health Facilities Planning Act.

1152. Purpose of Act

§ 2. The purpose of this Act is to establish a procedure designed to reverse the trends of increasing costs of health care resulting from unnecessary construction or modification of health care facilities. Such procedure shall represent an attempt by the State of Illinois to improve the financial ability of the public to obtain necessary health services, and to establish an orderly and comprehensive health care delivery system which will guarantee the availability of quality health care to the general public.

This Act shall establish a procedure (1) which requires a person establishing, constructing or modifying a health care facility, as herein defined, to have the qualifications, background, character and financial resources to adequately provide a proper service for the community; (2) that promotes through the process of recognized local and area-wide health facilities planning, the orderly and economic development of health care facilities in the State of Illinois that avoids unnecessary duplication of such facilities; (3) that promotes planning for and development of health care facilities needed for comprehensive health care especially in areas where the health planning process has identified unmet needs; and (4) that carries out these purposes in coordination with the Agency and the comprehensive State health plan developed by that Agency.

Amended by P.A. 80-941, § 1, eff. Sept. 22, 1977.

1153. Definitions

§ 3. As used in this Act: "Health care facilities" means and includes the following facilities and organizations:

1. An ambulatory surgical treatment center required to be licensed pursuant to the "Ambulatory Surgical Treatment Center Act", approved July 19, 1973, as amended;[1]

2. An institution, place, building, or agency required to be licensed pursuant to the "Hospital Licensing Act", approved July 1, 1953, as amended;[2]

3. Any institution required to be licensed pursuant to the "Nursing Home Care Reform Act of 1979", approved August 23, 1979, as amended;[3]

4. Hospitals, nursing homes, ambulatory surgical treatment centers or kidney disease treatment centers, or health maintenance organizations maintained by the State or any department or agency thereof;

5. Kidney disease treatment centers, including a free-standing hemodialysis unit; and

6. Any health maintenance organization required to be operated pursuant to the "Health Maintenance Organization Act", approved August 27, 1974, as now or hereafter amended,[4] and which:

(A) is a qualified health maintenance organization under Section 1310(d) of the Public Health Services Act;[5] or

(B) (i) provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physician services, hospitalization, laboratory, x-ray, emergency and preventive services, and out of area coverage; (ii) is compensated (except for co-payments) for the provision of the basic health care services listed in clause (i) to enrolled participants by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health service actually provided; and (iii) provides physicians' services primarily (I) direct-

ly through physicians who are either employees or partners of such organization, or (II) through arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

No federally owned facility shall be subject to the provisions of this Act, nor facilities used solely for healing by prayer or spiritual means.

With the exception of those health care facilities specifically included in this Section, nothing in this Act shall be intended to include facilities operated as a part of the practice of a physician or other licensed health care professional, whether practicing in his individual capacity or within the legal structure of any partnership, medical or professional corporation, or unincorporated medical or professional group. Further, this Act shall not apply to physicians or other licensed health care professional's practices where such practices are carried out in a portion of a health care facility under contract with such health care facility by a physician or by other licensed health care professionals, whether practicing in his individual capacity or within the legal structure of any partnership, medical or professional corporation, or unincorporated medical or professional groups. This Act shall apply to construction or modification and to establishment by such health care facility of such contracted portion which is subject to facility licensing requirements, irrespective of the party responsible for such action or attendant financial obligation.

"Person" means any one or more natural persons, legal entities, governmental bodies other than federal, or any combination thereof.

"Consumer" means any person other than a person (a) whose major occupation currently involves or whose official capacity within the last 12 months has involved the providing, administering or financing of any type of health care facility, (b) who is engaged in health research or the teaching of health, (c) who has a material financial interest

in any activity which involves the providing, administering or financing of any type of health care facility, or (d) who is or ever has been a member of the immediate family of the person defined by (a), (b), or (c).

"State Board" means the Health Facilities Planning Board.

"Construction or modification" means the establishment, erection, building, alteration, reconstruction, modernization, improvement, extension, discontinuation, change of ownership, of or by a health care facility, or the purchase or acquisition by or through a health care facility of equipment or service for diagnostic or therapeutic purposes or for facility administration or operation, or any capital expenditure made by or on behalf of a health care facility which exceeds the capital expenditure minimum.

"Establish" means the construction of a health care facility or the replacement of an existing facility on another site.

"Major medical equipment" means medical equipment which is used for the provision of medical and other health services and which costs in excess of the capital expenditure minimum, except that such term does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is independent of a physician's office and a hospital and it has been determined under Title XVIII of the Social Security Act[6] to meet the requirements of paragraphs (10) and (11) of Section 1861(s) of such Act.[7] In determining whether medical equipment has a value in excess of the capital expenditure minimum, the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of such equipment shall be included.

"Capital Expenditure" means an expenditure: (A) made by or on behalf of a health care facility (as such a facility is defined in this Act); and (B) which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or is made

to obtain by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part; and which exceeds the capital expenditure minimum.

For the purpose of this paragraph, the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if such expenditure exceeds the capital expenditures minimum. Donations of equipment or facilities to a health care facility which if acquired directly by such facility would be subject to review under this Act shall be considered capital expenditures, and a transfer of equipment or facilities for less than fair market value shall be considered a capital expenditure for purposes of this Act if a transfer of the equipment or facilities at fair market value would be subject to review.

"Capital expenditure minimum" means $400,000 for major medical equipment and $600,000 for all other capital expenditures, both of which shall be annually adjusted to reflect the increase in construction costs due to inflation.

"Areawide" means a major area of the State delineated on a geographic, demographic, and functional basis for health planning and for health service and having within it one or more local areas for health planning and health service. The term "region", as contrasted with the term "subregion", and the word "area" may be used synonymously with with term "areawide".

"Local" means a subarea of a delineated major area that on a geographic, demographic, and functional basis may be considered to be part of such major area. The term "subregion" may be used synonymously with the term "local".

"Areawide health planning organization" or "Comprehensive health planning organization" means the health systems agency designated by the Secretary, Department of Health, Education, and Welfare, pursuant to federal Public Law 93-641,[8] or any successor agency.

"Local health planning organization" means those local health planning organizations that are designated as such by the areawide health planning organization of the appropriate area.

"Physician" means a person licensed to practice in accordance with the Medical Practice Act, as amended.[9]

"Licensed health care professional" means a person licensed to practice a health profession under pertinent licensing statutes of the State of Illinois.

"Director" means the Director of the Illinois Department of Public Health.

"Agency" means the Illinois Department of Public Health.

"Comprehensive health planning" means health planning concerned with the total population and all health and associated problems that affect the well-being of people and that encompasses health services, health manpower, and health facilities; and the coordination among these and with those social, economic, and environmental factors that affect health.

Amended by P.A. 82-745, § 1, eff. May 7, 1982; P.A. 83-333, § 63, eff. Sept. 14, 1983.

[1] Paragraph 157.8-1 et seq. of this chapter.
[2] Paragraph 142 et seq. of this chapter.
[3] Paragraph 4151-101 et seq. of this chapter.
[4] Paragraph 1401 et seq. of this chapter.
[5] 42 U.S.C.A. § 300e-9.
[6] 42 U.S.C.A. § 1395 et seq.
[7] 42 U.S.C.A. § 1395x.
[8] 42 U.S.C.A. § 300k et seq.
[9] Chapter 111, ¶ 4401 et seq.

1153.1. Major medical equipment—Acquisition

§ 3.1. Until January 1, 1984 and not thereafter, any person proposing to acquire major medical equipment (as defined in this Act) is subject to the provisions of this

Act regarding obtaining a permit or exemption. The provisions of this Section shall be in effect until January 1, 1984, or the repeal of Public Law 93-641, as amended,[1] whichever shall come first.

Added by P.A. 82-745, § 1, eff. May 7, 1982.

[1] 42 U.S.C.A. § 300k et seq.

Paragraph effective until Jan. 1, 1984, or the repeal of the National Health Planning and Resources Development Act of 1974 (42 U.S.C.A. § 300k et seq.).

1154. Health Facilities Planning Board—Membership—Appointment—Term—Compensation—Quorum

§ 4. There is created the Health Facilities Planning Board, which shall perform such functions as hereinafter described in this Act.

The State Board shall consist of 13 voting members, including: 7 consumer members; one member representing the commercial health insurance industry in Illinois; one member representing the hospital service corporations in Illinois; one member who is actively engaged in the field of hospital management; one member who is a professional nurse registered in Illinois; one member who is a physician in active private practice licensed in Illinois to practice medicine in all of its branches; and one member who is actively engaged in the field of skilled nursing or intermediate care facility management.

The State Board shall be appointed by the Governor, with the advice and consent of the Senate. In making the appointments, the Governor shall give consideration to recommendations made by (1) the professional organizations concerned with hospital management for the hospital management appointment and (2) professional organizations concerned with long term care facility management for the long term care facility management appointment and (3) professional medical organizations for the physician appointment and (4) professional nursing organizations for the nurse appointment, and shall appoint as consumer

members individuals familiar with community health needs but whose interest in the operation, construction or utilization of health care facilities are derived from factors other than those related to his profession, business, or economic gain, and who represent, so far as possible, different geographic areas of the State. Not more than 7 of the appointments shall be of the same political party.

The Directors of the Illinois Departments of Public Aid, Mental Health and Public Health, or their designated representatives, shall serve as ex-officio, non-voting members of the State Board.

Of those appointed by the Governor as voting members, each member shall hold office for a term of 3 years: provided, that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term and the term of office of each successor shall commence on July 1 of the year in which his predecessor's term expires. In making original appointments to the State Board, the Governor shall appoint 5 members for a term of one year, 5 for a term of 2 years, and 3 for a term of 3 years, and each of these terms of office shall commence on July 1, 1974. Each member shall hold office until his successor is appointed and qualified.

No member shall serve more than 3 consecutive 3-year terms, except for those members who are ex-officio, non-voting members.

State Board members, while serving on business of the State Board, shall receive actual and necessary travel and subsistence expenses while so serving away from their places of residence. In addition, while serving on business of the State Board, each member shall receive compensation of $150 per day for each day served at regular or special meetings of the State Board or at committee meetings approved by the Chairman of the State Board, except that such compensation shall not exceed $7,500 in any one year for any member.

The State Board shall provide for its own organization and procedures, including the selection of a Chairman and such other officers as deemed necessary. The Director, with concurrence of the State Board, shall name as full-time Executive Secretary of the State Board, a person qualified in health care facility planning and in administration. The Agency shall provide administrative and staff support for the State Board. The State Board shall advise the Director of its budgetary and staff needs and consult with the Director on annual budget preparation.

The State Board shall meet at least once each quarter, or as often as the Chairman of the State Board deems necessary, or upon the request of a majority of the members.

Seven members of the State Board shall constitute a quorum. The affirmative vote of 7 of the members of the State Board shall be necessary for any action requiring a vote to be taken by the State Board. A vacancy in the membership of the State Board shall not impair the right of a quorum to exercise all the rights and perform all the duties of the State Board as provided by this Act.

Amended by P.A. 81-149, § 1, eff. Jan. 1, 1980.

1155. Permits or exemptions—Construction, modification or establishment of health care facilities—Acquisition of major medical equipment

§ 5. After effective dates set by the State Board, no person shall construct, modify or establish a health care facility or acquire major medical equipment without first obtaining a permit or exemption from the State Board. The State Board shall set effective dates applicable to all or to each classification or category of health care facilities and applicable to all or each type of transaction for which a permit is required. Varying effective dates may be set, providing the date or dates so set shall apply uniformly statewide.

Notwithstanding any effective dates established by this Act or by the State Board, no person shall be required to

obtain a permit for any purpose under this Act until the State health facilities plan referred to in paragraph (4) of Section 12 of this Act[1] has been approved and adopted by the State Board subsequent to public hearings having been held thereon.

A permit or exemption shall be obtained prior to the acquisition of major medical equipment or to the construction or modification of a health care facility which:

(a) requires a total capital expenditure in excess of the capital expenditure minimum; or

(b) substantially changes the scope or changes the functional operation of the facility; or

(c) changes the bed capacity of a health care facility by increasing or decreasing the total number of beds or by distributing beds among various categories of service or by relocating beds from one physical facility or site to another by more than 10 beds or more than 10% of total bed capacity as defined by the State Board, whichever is less, over a 2 year period.

A permit shall be valid only for the defined construction or modifications, site, amount and person named in the application for such permit and shall not be transferable or assignable. A permit shall be valid until such time as the project has been completed, provided that (a) obligation of the project occurs within 12 months following issuance of the permit except for major construction projects such obligation must occur with 18 months following issuance of the permit; and (b) the project commences and proceeds to completion with due diligence. Major construction projects, for the purposes of this Act, shall include but are not limited to: projects for the construction of new buildings; additions to existing facilities; modernization projects whose cost is in excess of $1,000,000 or 10% of the facilities' operating revenue, whichever is less; and such other projects as the State Board shall define and prescribe pursuant to this Act. The State Board may renew that permit for an additional reasonable length of time upon showing by the applicant that additional time

is required to complete the establishment, construction or modification of the health care facility or acquisition of major medical equipment.

Persons who otherwise would be required to obtain a permit shall be exempt from such requirement if the State Board finds that with respect to establishing a new facility or construction of new buildings or additions or modifications to an existing facility, final plans and specifications for such work have prior to October 1, 1974, been submitted to and approved by the Department of Public Health in accordance with the requirements of applicable laws. Such exemptions shall be null and void after December 31, 1979 unless binding construction contracts were signed prior to December 1, 1979 and unless construction has commenced prior to December 31, 1979. Such exemptions shall be valid until such time as the project has been completed provided that the project proceeds to completion with due diligence.

The acquisition by any person of major medical equipment that will not be owned by or located in a health care facility and that will not be used to provide services to inpatients of a health care facility shall be exempt from review provided that a notice is filed in accordance with exemption requirements.

Amended by P.A. 82-745, § 1, eff. May 7, 1982.

[1] Paragraph 1162 of this chapter.

1156. Application for permit or exemption—Exemption regulations

§ 6. An application for a permit or exemption shall be made to the State Board upon forms provided by the State Board. This application shall contain such information as the State Board deems necessary. Such application shall include affirmative evidence on which the Director may make the findings required under this Section and upon which the State Board may make its decision on the approval or denial of the permit or exemption.

The State Board shall establish by regulation the procedures and requirements regarding issuance of exemptions. Such exemptions shall be limited to those transactions specified by Title XV of the federal Public Health Services Act[1] and shall include acquisitions of existing health care facilities by any person.

All applications shall be signed by the applicant and shall be verified by any 2 officers thereof.

Upon receipt of an application for a permit, the State Board shall approve and authorize the issuance of a permit if it finds (1) that the applicant is fit, willing, and able to provice a proper standard of health care service for the community with particular regard to the qualification, background and character of the applicant, (2) that economic feasibility is demonstrated in terms of effect on the existing and projected operating budget of the applicant and of the health care facility; in terms of the applicant's ability to establish and operate such facility in accordance with licensure regulations promulgated under pertinent state laws; and in terms of the projected impact on the total health care expenditures in the facility and community, (3) that safeguards are provided which assure that the establishment, construction or modification of the health care facility or acquisition of major medical equipment is consistent with the public interest, and (4) that the proposed project is consistent with the orderly and economic development of such facilities and equipment and is in accord wi standards, criteria, or plans of need adopted and approved pursuant to the provisions of Section 12 of this Act.[2]

Amended by P.A. 82-745, § 1, eff. May 7, 1982.

[1] 42 U.S.C.A. § 300u et seq.

[2] Paragraph 1162 of this chapter.

1156.1. Submission of applications—Timetable

§ 6.1. The State Board shall require applications to be submitted in accordance with a timetable established by the State Agency, and review all completed applications

pertaining to similar types of services, facilities, or equipment affecting the same health service area in relation to each-other (but no less often than twice a year).

The State Board shall specify when applications may be exempted from this timetable and from being reviewed in relation to each other.

The provisions of this Section shall be in effect until January 1, 1984, or the repeal of Public Law 93-641, as amended,[1] whichever shall come first.

Added by P.A. 82-745, § 1, eff. May 7, 1982.

[1] 42 U.S.C.A. § 300k et seq.

Paragraph effective until Jan. 1, 1984, or the repeal of the National Health Planning and Resources Development Act of 1974 (42 U.S.C.A. § 300k et seq.).

1157. Cooperation of other agencies in obtaining information relating to applications

§ 7. The Director of the State Board may request the cooperation of county and multiple-county health departments, municipal boards of health, and other governmental and nongovernmental agencies in obtaining information and in conducting investigations relating to applications for permits.

Amended by P.A. 80-941, § 1, eff. Sept. 22, 1977.

1158. Areawide health planning organizations

§ 8. The Agency shall assist communities and regions throughout the State to establish areawide health planning organizations and, in particular, shall assist such organizations to develop health care facilities planning which meets the criteria for recognition thereof. Areawide health planning organizations may be recognized to do health facilities planning by providing this component of health planning within the organization or by contracting with a special-purpose health planning organization that meets the criteria for health facilities planning.

Recognition of these organizations with regard to health facilities planning, including establishment of the criteria for such recognition, shall be the responsibility of the State Board, as provided elsewhere in this Act.

The Agency is authorized to make grants-in-aid or to furnish direct services to organizations in the development of health facilities planning capability, as a part of other financial and service assistance which the Agency is empowered and required to provide in support of health planning organizations.

Upon receipt of an application for a permit to establish, construct or modify a health care facility, the Agency shall notify the applicant in writing within 10 working days either that the application is complete or the reasons why the application is not complete. If the application is complete, the Agency shall notify affected persons of the beginning of a review and the review time cycle for the purposes of this Act shall begin on the date this notification is mailed.

Upon notifying affected persons of the beginning of a review of an application for a permit, a complete copy of such application shall be transmitted to the areawide health planning organization serving the area or community where the health care facility or major medical equipment is proposed to be acquired, established, constructed or modified. The Agency shall also transmit a complete copy of such application to any reasonably contiguous areawide health planning organization. The Agency shall afford a reasonable time as established by the State Board, but not to exceed 120 days in length, for the areawise planning organizations' review of the application. After reviewing the application, each recognized areawide planning organization shall certify its findings to the State Board as to whether or not the application is approved or disapproved in accordance with standards, criteria or plans of need adopted and approved by the recognized areawide health planning organization pursuant to its recognition by the State Board for health care facilities planning. The 120-day period shall begin on the day the ap-

plication is found to be substantially complete, as that term is defined by the State Board. During such 120-day period, the applicant may request an extension. An applicant may modify the application at any time prior to a final administrative decision on the application.

Upon its receipt of an application, the areawide health planning organization or the Agency, as the case may be, may submit a copy of such application to the federally-recognized professional standards review organization, if any, and appropriate local health planning organization, if any, existing in the area where the proposed project is to occur. Such organizations may review the application for a permit and submit, within 30 days from the receipt of the application, a finding to the agency or to the areawide health planning organization, as the case may be. A review and finding by a federally-recognized professional standards review organization must be relevant to the activities for which such organization is recognized, and shall be considered by the Agency or the areawide health planning organization, as the case may be, in its review of the application.

The State Board shall prescribe and provide the forms upon which the review and finding of the organization shall be made. The recognized areawide health planning organizations shall submit their review and finding to the Agency for its finding on the application and transmittal to the State Board for its consideration of denial or approval. Whenever the State Board renders a decision on an application which is contrary to the finding of the areawide health planning organization or agency thereon, that organization shall be provided a written detailed statement of the reasons for the inconsistency and shall be afforded an opportunity for a hearing before a hearing officer, who is appointed by the State Board. Such hearing shall be conducted in accordance with the provisions specified in Section 10 of this Act.[1]

If there is no areawide health planning organization in the area where the proposed establishment, construction or modification of a health care facility is to occur, then

the Agency shall be afforded a reasonable time, but not to exceed 120 days, for its review and finding thereon. The Agency shall submit its review and finding to the State Board for its approval or denial of the permit.

When an application for a permit is initially reviewed by a recognized areawide health planning organization or the Agency, as herein provided, the organization or the Agency, as the case may be, shall afford an opportunity for a public hearing within a reasonable time after receipt of the complete application, not to exceed 90 days. Notice of such hearing shall be made promptly by certified mail to the applicant and, within 10 days of the hearing, by publication in a newspaper of general circulation in the area or community to be affected. Such hearing shall be conducted in the area or community where the proposed project is to occur, and shall be for the purpose of allowing the applicant and any interested person to present public testimony concerning the approval, denial, renewal or revocation of the permit. All interested persons attending such hearing shall be given reasonable opportunity to present their views or arguments in writing or orally, and a record of all such testimony shall accompany any recommendation of the Agency or the recognized areawide health planning organization for the issuance, denial, revocation or renewal of a permit to the State Board. The State Board shall promulate reasonable rules and regulations governing the procedure and conduct of such hearings.

Amended by P.A. 82-745, § 1, eff. May 7, 1982.

[1] Paragraph 1160 of this chapter.

1159. Certificate of recognition—Application—Hearing

§ 9. An application for a certificate of recognition for an areawide health planning organization for health facilities planning shall be made to the State Board upon forms provided by it and shall contain evidence that standards, criteria and plans of need have been adopted and approved by the organization for health care facilities planning for

the area which the applicant intends to serve and such other information as may reasonably be required. All such applications for a certificate of recognition shall be submitted to the State Board and evaluated by the Agency. If the Agency finds that the applicant for a certificate of recognition for health facilities planning meets the criteria established under this Act, it shall submit its recommendation of approval to the State Board. A certificate of recognition shall be approved by the State Board and shall be valid for such period as the State Board, upon its findings determines that the recognized areawide health planning organization continues to comply with the criteria for recognition. The State Board shall annually review the certificate of recognition and afford an opportunity for public comment in order to determine that the recognized areawide health planning organization continues to comply with the criteria for recognition. A certificate of recognition may be revoked by the State Board, following opportunity for appeal and hearing as provided in this Act. Upon loss of recognition, funds awarded to the areawide health planning organization by the Agency pursuant to this Act shall be terminated.

When an application for a certificate of recognition of an areawide health planning organization for health facilities planning is made to the State Board, the Agency shall conduct a public hearing within a reasonable period after receipt of the application, not to exceed 90 days. Notice of such hearing shall be made promptly to the applicant by certified mail and by publication in a newspaper of general circulation in the area where the applicant intends to conduct health facilities planning. Such hearings shall be conducted by the Agency in the area affected, and shall be for the purpose of allowing the applicant and all interested parties to present public testimony concerning the approval, denial or revocation of a certificate of recognition. All interested parties attending such hearing shall be given reasonable opportunity to present their views orally or in writing, and a record of such testimony shall be transmitted to the State Board by the Agency. The State Board shall consider all testimony submitted by the

Agency pursuant to the public hearing in conjunction with the recommendation of the Agency for the approval, denial or revocation of the certificate of recognition.

Amended by P.A. 81-149, § 1, eff. Jan. 1, 1980.

1160. Denial of application for permit or renewal thereof or a certificate of recognition—Appearance—Hearing—Record—Review under Administrative Review Law—Witnesses

§ 10. When a motion by the State Board, to approve an application for a permit, a renewal thereof or a certificate of recognition, fails to pass, or when a motion to deny an application for permit, a renewal thereof or a certificate of recognition, is passed, the applicant or a holder of a permit, as the case may be, and such other parties as the State Board permits, will be given an opportunity to appear before the State Board and present such information as may be relevant to the approval of a permit or certificate or renewal or in resistance of a denial of the application.

Subsequent to an appearance by the applicant before the State Board or default of such opportunity to appear, a motion by the State Board to approve an application for permit, a renewal thereof or a certificate of recognition which fails to pass or a motion to deny an application for permit, a renewal thereof or a certificate of recognition which passes shall be considered denial of the application for permit, renewal thereof, or certificate of recognition, as the case may be. Such action of denial or an action by the State Board to revoke a permit or a certificate of recognition shall be communicated to the applicant or holder of the permit or certificate of need. Such person or organization shall be afforded an opportunity for a hearing before a hearing officer, who is appointed by the State Board. A written notice of a request for such hearing shall be served upon the Chairman of the State Board within 30 days following notification of the decision of the State Board. The State Board shall schedule

a hearing within 30 days thereafter. Following its consideration of the report of the hearing, or upon default of the party to the hearing, the State Board shall make its final determination, specifying its findings and conclusions. A copy of such determination shall be sent by certified mail or served personally upon the party.

A full and complete record shall be kept of all proceedings, including the notice of hearing, complaint, and all other documents in the nature of pleadings, written motions filed in the proceedings, and the report and orders of the State Board or hearing officer. All testimony shall be reported but need not be transcribed unless the decision is appealed in accordance with Administrative Review Law, as now or hereafter amended.[1] A copy or copies of the transcript may be obtained by any interested party on payment of the cost of preparing such copy or copies.

The State Board or hearing officer shall upon its own or his motion, or on the written request of any party to the proceeding who has, in the State Board's or hearing officer's opinion, demonstrated the relevancy of such request to the outcome of the proceedings, issue subpoenas requiring the attendance and the giving of testimony by witnesses, and subpoenas duces tecum requiring the production of books, papers, records, or memoranda. The fees of witnesses for attendance and travel shall be the same as the fees of witnesses before the circuit court of this State.

When the witness is subpoenaed at the instance of the State Board, or its hearing officer, such fees shall be paid in the same manner as other expenses of the Agency, and when the witness is subpoenaed at the instance of any other party to any such proceeding the State Board may, in accordance with the rules of the Agency, require that the cost of service of the subpoena or subpoena duces tecum and the fee of the witness be borne by the party at whose instance the witness is summoned. In such case, the State Board in its discretion, may require a deposit to cover the cost of such service and witness fees. A subpoena or subpoena duces tecum so issued shall be served in the same manner as a subpoena issued out of a court.

Any circuit court of this State upon the application of the State Board or upon the application of any other party to the proceeding, may, in its discretion, compel the attendance of witnesses, the production of books, papers, records, or memoranda and the giving of testimony before it or its hearing officer conducting an investigation or holding a hearing authorized by this Act, by an attachment for contempt, or otherwise, in the same manner as production of evidence may be compelled before the court.

The State Board or its hearing officer, or any party to a hearing under this Act, may cause the depositions of witnesses within the State to be taken in the manner prescribed by law for like depositions in civil actions in courts of this State, and to that end compel the attendance of witnesses and the production of books, papers or memoranda.

Amended by P.A. 82-783, Art. XI, § 215, eff. July 13, 1982.

[1] Chapter 110, ¶ 3-101 et seq.

1161. Review under Administrative Review Law

§ 11. Any person who is adversely affected by a final decision of the State Board may have such decision judicially reviewed. The provisions of the Administrative Review Law, as now or hereafter amended,[1] and the rules adopted pursuant thereto shall apply to and govern all proceedings for the judicial review of final administrative decisions of the State Board. The term "administrative decisions" is as defined in Section 3-101 of the Code of Civil Procedure.[2]

Amended by P.A. 82-745, § 1, eff. May 7, 1982; P.A. 82-783, Art. XI, § 215, eff. July 13, 1982; P.A. 82-1057, Art. II, § 16, eff. Feb. 11, 1983.

[1] Chapter 110, ¶ 3-101 et seq.

[2] Chapter 110, ¶ 3-101.

Article II of P.A. 82-1057, the 2nd 1982 Revisory Act, resolved multiple actions of the 82nd General Assembly through P.A. 82-1016.

1162. Powers and duties of agency

§ 12. For purposes of this Act, the Agency shall exercise the following powers and duties:

(1) Prescribe, with prior approval of the State Board, rules, regulations, standards, criteria, procedures or reviews which may vary according to the purpose for which a particular review is being conducted or the type of project reviewed and which are required to carry out the provisions and purposes of this Act;

(2) Adopt, with approval of the State Board, procedures for public notice and hearing on all proposed rules, regulations, standards, criteria, and plans required to carry out the provisions of this Act;

(3) Prescribe, with prior approval of the State Board, criteria for recognition for areawide health planning organizations, including, but not limited to, standards for evaluating the scientific bases for judgments on need and procedure for making these determinations;

(4) Develop criteria and standards for health care facilities planning, conduct statewide inventories of health care facilities, and develop health care facility plans which, upon adoption by the State Board, shall be utilized in the review of applications for permit under this Act. Such health facility plans shall be coordinated by the Agency with the health care facility plans areawide health planning organizations and with other pertinent State Plans.

In developing health care facility plans, the Agency should consider but not be limited to the following:

(a) The size, composition and growth of the population of the area to be served;

(b) The number of existing and planned facilities offering similar programs;

(c) The extent of utilization of existing facilities;

(d) The availability of facilities which may serve as alternatives or substitutes;

(e) The availability of personnel necessary to the operation of the facility;

(f) Multi-institutional planning and the establishment of multi-institutional systems where feasible;

(g) The financial and economic feasibility of proposed construction or modification;

(h) In the case of health care facilities established by a religious body or denomination, the needs of the members of such religious body or denomination may be considered to be public need; and

(i) The provisions of Sections 1527, 1531 and 1532, Title XV, of the federal Public Health Services Act.[1]

The health care facility plans which are developed and adopted in accordance with this Section shall form the basis for the plan of the State to deal most effectively with statewide health needs in regard to health care facilities.

(5) Coordinate with other state agencies having responsibilities affecting health care facilities, including those of licensure and cost reporting;

(6) Coordinate with Federal agencies the procedures established by this Act and the required functions to be established by the Agency for purposes of carrying out the duties and powers which have been designated to the Agency under the provisions of Sec. 1122, Title XI, of the Social Security Act;[2]

(7) Solicit, accept, hold and administer on behalf of the State any grants or bequests of money, securities or property to the Agency for use by the State Board, the Agency or recognized areawide health planning organizations in the administration of this Act;

(8) Charge and collect from the permit applicant an amount determined by the State Board to be a reasonable

application fee for the processing of the application by the State Board, the Agency and the appropriate recognized areawide health planning organization. The State Board shall set the amount by regulation. All fees collected under the provision of this Act shall be deposited with the State Treasurer;

(9) Where local resources are not sufficient, to provide the necessary technical and financial assistance to recognized areawide health planning organizations to assist in the planning which will enable the organization to effectively carry out the functions provided for it in this Act;

(10) In addition to all powers and duties required of the Agency and the State Board pertaining to applications for a permit for the construction or modification of health care facilities, the Agency shall prescribe, with the prior approval of the State Board and in consultation with the recognized areawide health planning organizations, procedures for review, standards and criteria which the State Board, upon adoption thereof, shall utilize to make periodic areawide reviews and determinations of the appropriateness of any existing health services being rendered by health care facilities subject to the Act. The State Board shall consider recommendations of the areawide health planning organization and the Agency in making its determinations;

(11) Prescribe, with prior approval of the State Board in consultation with the recognized areawide health planning organizations, rules, regulations, standards and criteria for the conduct of an expeditious review of applications for permits for projects of construction or modification of a health care facility, which projects are non-substantive in nature. Such rules shall not abridge the right of areawide health planning organizations to make recommendations on the classification and approval of projects, nor shall such rules prevent the conduct of a public hearing upon the timely request of an interested party. Such reviews shall not exceed 60 days from the date the application is declared to be complete by the Agency;

(12) Prescribe, with prior approval of the State Board, rules, regulations, standards and criteria pertaining to the granting of permits for construction and modifications which are emergent in nature and must be undertaken immediately to prevent or correct structural deficiencies or hazardous conditions that may harm or injure persons using the facility, as defined in the rules and regulations of the State Board. This procedure is exempt from public hearing requirements of this Act.

Amended by P.A. 82-745, § 1, eff. May 7, 1982.

[1] 42 U.S.C.A. §§ 300m-6, 300n and 300n-1.

[2] 42 U.S.C.A. § 1320a-1.

1163. Investigations of applications for permits and certificates of recognition

§ 13. The Agency or the State Board shall make or cause to be made such investigations as it or the State Board deems necessary in connection with an application for a permit or an application for a certificate of recognition, or in connection with a determination of whether or not construction or modification which has been commenced is in accord with the permit issued by the State Board or whether construction or modification has been commenced without a permit having been obtained. The State Board may issue subpoenas duces tecum requiring the production of records and may administer oaths to such witnesses.

Any circuit court of this State, upon the application of the State Board or upon the application of any party to such proceedings, may, in its discretion, compel the attendance of witnesses, the production of books, papers, records, or memoranda and the giving of testimony before the State Board, by a proceeding as for contempt, or otherwise, in the same manner as production of evidence may be compelled before the court.

The Agency shall require all health facilities operating in this State to provide such reasonable reports at such times and containing such information as is needed by it

to carry out the purposes and provisions of this Act. Health facilities not complying with this requirement shall be reported to licensing, accrediting, certifying, or payment agencies as being in violation of State law. Health care facilities and other parties at interest shall have reasonable access, under rules established by the State Board, to all planning information submitted in accord with this Act pertaining to their area.

Amended by P.A. 80-941, § 1, eff. Sept. 22, 1977.

T163.1. Necessity of permit

§ 13.1. Any person constructing or modifying a health care facility or portion thereof without obtaining a required permit shall not be eligible to apply for any necessary operating licenses or be eligible for payment by any State agency for services rendered in that facility or portion thereof until the required permit is obtained.

Added by P.A. 80-941, § 1, eff. Sept. 22, 1977.

1164. Violations—Fine

§ 14. Any person acquiring major medical equipment or establishing, constructing or modifying a health care facility without a permit issued under this Act or in violation of the terms of such a permit is guilty of a business offense and may be fined up to $10,000. The State's Attorneys of the several counties or the Attorney General shall represent the People of the State of Illinois in proceedings under this Section.

Amended by P.A. 82-745, § 1, eff. May 7, 1982.

1165. Proceedings to prevent acquisition of major medical equipment or the establishment, construction or modification of health care facility

§ 15. Notwithstanding the existence or pursuit of any other remedy, the Agency may, in the manner provided by law, upon the advice of the Attorney General who shall

represent the Agency in the proceedings, maintain an action in the name of the State for injunction or other process against any person or governmental unit to restrain or prevent the acquisition of major medical equipment, the establishment, construction or modification of a health care facility without the required permit, or to restrain or prevent the occupancy or utilization of the equipment acquired or facility which was constructed or modified without the required permit.

Amended by P.A. 82-745, § 1, eff. May 7, 1982.

1165.1. Individual liability for damages

§ 15.1. No individual who, as a member of the State Board or of an areawide health planning organization board, or as an employee of the State or of an areawide health planning organization, shall, by reason of his performance of any duty, function, or activity required of, or authorized to be undertaken by this Act, be liable for the payment of damages under any law of the State, if he has acted within the scope of such duty, function, or activity, has exercised due care, and has acted, with respect to that performance, without malice toward any person affected by it.

Added by P.A. 80-941, § 1, eff. Sept. 22, 1977.

1166. Partial invalidity

§ 16. If any provision of this Act or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of this Act which can be given effect without the invalid provision or application, and to this end the provisions of the Act are declared to be severable.

1167. Home rule unit—Exercise of powers and functions

§ 17. It is hereby specifically declared that the powers and functions exercised and performed by the State pursuant to this Act are exclusive to the State of Illinois and

that these powers and functions shall not be exercised, either independently or concurrently, by any home rule unit.

1168. Administrative Procedure Act—Application

§ 18. The Illinois Administrative Procedure Act, as now or hereafter amended,[1] is hereby expressly adopted and incorporated herein and shall apply to the State Board and the Agency as if all of the provisions of such Act were included in this Act; except that in case of a conflict between the Administrative Procedure Act and this Act the provisions of this Act shall control. This Section applies to the Agency and the State Board 6 months after the effective date of this amendatory Act of 1977.

Added by P.A. 80-818, § 1, eff. Sept. 20, 1977.

[1] Chapter 127, ¶ 1001 et seq.

APPENDIX K

Medical Practice Act
111 Ill. Rev. Stat. ¶ 4400-22

4400-22. Disciplinary action—Grounds

§ 22. A. The Department may revoke, suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license or visiting professor permit of any person issued under this Act to practice medicine, or to treat human ailments without the use of drugs and without operative surgery upon any of the following grounds:

1. Performance of an elective abortion in any place, locale, facility, or institution other than:

(a) a facility licensed pursuant to the "Ambulatory Surgical Treatment Center Act" as heretofore or hereafter amended;[1]

(b) an institution licensed pursuant to "An Act relating to the inspection, supervision, licensing, and regulation of hospitals" approved July 1, 1953, as heretofore or hereafter amended;[2] or

(c) an ambulatory surgical treatment center or hospitalization or care facility maintained by the State or any agency thereof, where such department or agency has authority under law to establish and enforce standards for the ambulatory surgical treatment centers, hospitalization, or care facilities under its management and control; or

(d) ambulatory surgical treatment centers, hospitalization or care facilities maintained by the Federal Government; or

(e) ambulatory surgical treatment centers, hospitalization or care facilities maintained by any university or college established under the laws of this State and supported principally by public funds raised by taxation;

2. Performance of an abortion procedure in a wilful and wanton manner on a woman who was not pregnant at the time the abortion procedure was performed;

3. The conviction of a felony in this or any other jurisdiction, except as otherwise provided in subsection B of this Section, whether or not related to practice under this Act, or the entry of a guilty or nolo contendere plea to a felony charge;

4. Gross negligence in practice under this Act;

5. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public;

6. Obtaining any fee by fraud, deceit, or misrepresentation;

7. Habitual or excessive use or abuse of drugs defined in law as controlled substances, of alcohol, or of any other substances which results in the inability to practice with reasonable judgment, skill or safety;

8. Practicing under a false or, except as provided by law, an assumed name;

9. Fraud or misrepresentation in applying for, or procuring, a license under this Act or in connection with applying for renewal of a license under this Act;

10. Making a false or misleading statement regarding their skill or the efficacy or value of the medicine, treatment, or remedy prescribed by them at their direction in the treatment of any disease or other condition of the body or mind;

11. Allowing another person or organization to use their license, procured under this Act, to practice;

12. Disciplinary action of another state or jurisdiction against a license or other authorization to practice as a medical doctor, doctor of osteopathy or doctor of chiropractic, a certified copy of the record of the action taken by the other state or jurisdiction being prima facie evidence thereof;

13. Violation of any provision of this Act or of the "Medical Practice Act", approved June 30, 1923, as amended,[3] prior to the repeal of that Act, or violation of the rules, or a final administrative action of the Director, after consideration of the recommendation of the Disciplinary Board;

14. Dividing with anyone other than physicians with whom the licensee practices in a partnership, Professional Association or Medical or Professional Corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered. Nothing contained in this subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in partnership under a partnership agreement or in a corporation authorized by "The Medical Corporation Act", as now or hereafter amended,[4] or as an association authorized by "The Professional Association Act" as now or hereafter amended,[5] or under "The Professional Corporation Act" as now or hereafter amended,[6] or from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection prohibits 2 or more corporations authorized by "The Medical Corporation Act", as now or hereafter amended, from forming a partnership or joint venture of such corporations, and providing medical, surgical and scientific research and knowledge by employees of these corporations if such employees are licensed under this Act, or from pooling, sharing, dividing, or apportioning the fees and monies received by the partnership or joint venture in accordance with the partnership or joint venture agreement. Nothing contained in this subsection shall abrogate the right of 2 or more persons, holding valid and current licenses under this Act, to each receive adequate compensation for concurrently rendering professional services to a patient and divide a fee; provided, the patient has full knowledge of the division, and, provided, that the division

is made in proportion to the services performed and responsibility assumed by each;

15. A finding by the Medical Disciplinary Board that the registrant after having his or her license placed on probationary status or subjected to conditions or restrictions violated the terms of the probation or failed to comply with such terms or conditions;

16. Abandonment of a patient;

17. Prescribing, selling, administering, distributing, giving or self-administering any drug classified as a controlled substance (designated product) or narcotic for other than medically accepted therapeutic purposes;

18. Promotion of the sale of drugs, devices, appliances or goods provided for a patient in such manner as to exploit the patient for financial gain of the physician;

19. Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine, or the treating, operating or prescribing for any human condition by a method, means or procedure which the licensee refuses to divulge upon demand of the Department;

20. Immoral conduct in the commission of any act related to the licensee's practice;

21. Wilfully making or filing false records or reports in his or her practice as a physician, including, but not limited to, false records to support claims against the medical assistance program of the Department of Public Aid under the Public Aid Code;[7]

22. Wilful omission to file or record, or wilfully impeding the filing or recording, or inducing another person to omit to file or record, medical reports as required by law, or wilfully failing to report an instance of suspected abuse or neglect as required by law;

23. Being named as a perpetrator in an indicated report by the Department of Children and Family Services pur-

suant to the Abused and Neglected Child Reporting Act, approved June 26, 1975, as now or hereafter amended,[8] and upon proof by clear and convincing evidence that the licensee has caused a child to be an abused child or neglected child as defined in the Abused and Neglected Child Reporting Act;

24. Solicitation of professional patronage by any corporation, agents or persons, or profiting from those representing themselves to be agents of the licensee;

25. Gross and wilful and continued overcharging for professional services, including filing false statements for collection of fees for which services are not rendered, including, but not limited to, filing such false statements for collection of monies for services not rendered from the medical assistance program of the Department of Public Aid under the Public Aid Code;

26. A pattern of practice or other behavior which demonstrates incapacity or incompetence to practice under this Act;

27. Mental illness or disability which results in the inability to practice under this Act with reasonable judgment, skill or safety;

28. Physical illness, including, but not limited to, deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice under this Act with reasonable judgment, skill or safety;

29. Cheating on or attempt to subvert the licensing examinations administered under this Act;

30. Wilfully or negligently violating the confidentiality between physician and patient except as required by law;

31. The use of any false, fraudulent, or deceptive statement in any document connected with practice under this Act;

32. Aiding and abetting an individual not licensed under this Act in the practice of a profession licensed under this Act;

33. Violating state or federal laws or regulations relating to controlled substances;

34. Failure to report to the Department any adverse final action taken against them by another licensing jurisdiction (any other state or any territory of the United States or any foreign state or country), by any peer review body, by any health care institution, by any professional society or association related to practice under this Act, by any governmental agency, by any law enforcement agency, or by any court for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this Section;

35. Failure to report to the Department surrender of a license or authorization to practice as a medical doctor, a doctor of osteopathy or doctor of chiropractic in another state or jurisdiction, or surrender of membership on any medical staff or in any medical or professional association or society, while under disciplinary investigation by any of those authorities or bodies, for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this Section;

36. Failure to report to the Department any adverse judgment, settlement, or award arising from a liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this Section;

37. Failure to transfer copies of medical records as required by law;

38. Failure to furnish the Department, its investigators or representatives, relevant information, legally requested by the Department after consultation with the Chief Medical Coordinator or the Deputy Medical Coordinator;

All proceedings to suspend, revoke, place on probationary status, or take any other disciplinary action as the Department may deem proper, with regard to a license on any of the foregoing grounds, must be commenced within

3 years next after receipt by the Department of a complaint alleging the commission of or notice of the conviction order for any of the acts described herein. Except for the grounds numbered (8), (9) and (29), no action shall be commenced more than 5 years after the date of the incident or act alleged to have violated this Section. In the event of the settlement of any claim or cause of action in favor of the claimant or the reduction to final judgment of any civil action in favor of the plaintiff, such claim, cause of action or civil action being grounded on the allegation that a person licensed under this Act was negligent in providing care, the Department shall have an additional period of one year from the date of such settlement or final judgment in which to investigate and commence formal disciplinary proceedings under Section 36 of this Act,[9] except as otherwise provided by law. The time during which the holder of the license was outside the State of Illinois shall not be included within any period of time limiting the commencement of disciplinary action by the Department.

The entry of an order or judgment by any circuit court establishing that any person holding a license under this Act is a person in need of mental treatment operates as a suspension of that license. That person may resume their practice only upon the entry of a Departmental order based upon a finding by the Medical Disciplinary Board that they have been determined to be recovered from mental illness by the court and upon the Disciplinary Board's recommendation that they be permitted to resume their practice.

The Department may refuse to issue or may suspend the license of any person who fails to file a return, or to pay the tax, penalty or interest shown in a filed return, or to pay any final assessment of tax, penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirements of any such tax Act are satisfied.

The Department, upon the recommendation of the Disciplinary Board, shall adopt rules which set forth standards to be used in determining:

(a) When a person will be deemed sufficiently rehabilitated to warrant the public trust;

(b) What constitutes dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud, or harm the public;

(c) What constitutes immoral conduct in the commission of any act related to the licensee's practice; and

(d) What constitutes gross negligence in the practice of medicine.

However, no such rule shall be admissible into evidence in any civil action except for review of a licensing or other disciplinary action under this Act.

In enforcing this Section, the Illinois State Medical Disciplinary Board, upon a showing of a possible violation, may compel any individual licensed to practice under this Act, or who has applied for licensure or certification pursuant to this Act, to submit to a mental or physical examination, or both, as required by and at the expense of the Department. The examining physician or physicians shall be those specifically designated by the Disciplinary Board. The individual to be examined may have, at his or her own expense, another physician of his or her choice present during all aspects of the examination. Failure of any individual to submit to mental or physical examination, when directed, shall be grounds for suspension of his or her license until such time as the individual submits to the examination if the Disciplinary Board finds, after notice and hearing, that the refusal to submit to the examination was without reasonable cause. If the Disciplinary Board finds a physician unable to practice because of the reasons set forth in this Section, the Disciplinary Board shall require such physician to submit to care, counseling, or treatment by physicians approved or designated

by the Disciplinary Board, as a condition for continued, reinstated, or renewed licensure to practice. Any physician, whose license was granted pursuant to Sections 9, 17, or 19 of this Act,[10] or, continued, reinstated, renewed, disciplined or supervised, subject to such terms, conditions or restrictions who shall fail to comply with such terms, conditions or restrictions, or to complete a required program of care, counseling, or treatment, as determined by the Chief Medical Coordinator or Deputy Medical Coordinators, shall be referred to the Director for a determination as to whether the licensee shall have their license suspended immediately, pending a hearing by the Disciplinary Board. In instances in which the Director immediately suspends a license under this Section, a hearing upon such person's license must be convened by the Disciplinary Board within 15 days after such suspension and completed without appreciable delay. The Disciplinary Board shall have the authority to review the subject physician's record of treatment and counseling regarding the impairment, to the extent permitted by applicable federal statutes and regulations safeguarding the confidentiality of medical records.

An individual licensed under this Act, affected under this Section, shall be afforded an opportunity to demonstrate to the Disciplinary Board that they can resume practice in compliance with acceptable and prevailing standards under the provisions of their license.

The Department may promulgate rules for the imposition of fines in disciplinary cases, not to exceed $5,000 for each violation of this Act. Fines may be imposed in conjunction with other forms of disciplinary action, but shall not be the exclusive disposition of any disciplinary action arising out of conduct resulting in death or injury to a patient. Any funds collected from such fines shall be deposited in the Medical Disciplinary Fund.

B. The Department shall revoke the license or visiting professor permit of any person issued under this Act to practice medicine or to treat human ailments without the

use of drugs and without operative surgery, who has been convicted a second time of committing any felony under the Illinois Controlled Substances Act,[11] as amended, or who has been convicted a second time of committing a Class 1 felony under Sections 8A-3 and 8A-6 of The Illinois Public Aid Code, as amended.[12] A person whose license or visiting professor permit is revoked under this subsection B of Section 22 of this Act shall be prohibited from practicing medicine or treating human ailments without the use of drugs and without operative surgery.

Amended by P.A. 85-686, § 2, eff. Sept. 22, 1987.

[1] Chapter 111½, ¶ 157-8.1 et seq.

[2] Chapter 111½, ¶ 142 et seq.

[3] Paragraph 4401 et seq. of this chapter (repealed; see, now, ¶ 4400-1 et seq. of this chapter).

[4] Chapter 32, ¶ 631 et seq.

[5] Chapter 106½, ¶ 101 et seq.

[6] Chapter 32, ¶ 415-1 et seq.

[7] Chapter 23, ¶ 1-1 et seq.

[8] Chapter 23, ¶ 2051 et seq.

[9] Paragraph 4400-36 of this chapter.

[10] Paragraph 4400-9, 4400-17 or 4400-19 of this chapter.

[11] Chapter 56½, ¶ 1100 et seq.

[12] Chapter 23, ¶¶ 8A-3 and 8A-6.

APPENDIX L

77 Illinois Administrative Code,
Chapter 1, § 205, Subchapter b

TITLE 77: PUBLIC HEALTH
CHAPTER 1: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER b: HOSPITAL AND AMBULATORY CARE FACILITIES

PART 205
AMBULATORY SURGICAL TREATMENT CENTER LICENSING REQUIREMENTS

SUBPART A: GENERAL

Section
205.110 Definitions
205.120 Licensure

SUBPART B: OWNERSHIP AND MANAGEMENT

Section
205.210 Ownership, Control and Management
205.220 Organizational Plan
205.230 Standards of Professional Work
205.240 Policies and Procedures Manual

SUBPART C: PERSONNEL

Section
205.310 Personnel Policies
205.320 Presence of Qualified Physician
205.330 Nursing Personnel
205.340 Basic Life Support
205.350 Ambulatory Surgical Treatment Center

SUBPART D: EQUIPMENT, SUPPLIES, AND FACILITY MAINTENANCE

Section
205.410 Equipment
205.420 Sanitary Facility

SUBPART E: GENERAL PATIENT CARE

Section
205.510 Emergency Care
205.520 Preoperative Care
205.530 Operative Care
205.540 Postoperative Care

SUBPART F: RECORDS AND REPORTS

Section
205.610 Clinical Records
205.620 Statistical Data

SUBPART G: ADDITIONAL REQUIREMENTS FOR FACILITIES IN WHICH OBSTETRICAL/ GYNECOLOGICAL PROCEDURES ARE PERFORMED

Section
205.710 Abortions
205.720 Personnel
205.730 General Patient Care
205.740 Preoperative Requirements
205.750 Postoperative Requirements
205.760 Reports

SUBPART H: PROCEDURES FOR INVESTIGATION OF COMPLAINTS

Section
205.810 Complaints
205.820 Acknowledgement of Complaint
205.830 Investigation
205.840 Prompt Investigation
205.850 Methods
205.860 Notification of Results

SUBPART I: BUILDING DESIGN, CONSTRUCTION STANDARDS, AND PHYSICAL REQUIREMENTS

Section
205.1310 Plant and Service Requirements
205.1320 General Considerations
205.1330 New Construction, Additions and Major Alterations
205.1340 Minor Alterations and Remodeling Changes
205.1350 Administration Department and Public Areas
205.1360 Clinical Facilities
205.1370 Support Service Areas
205.1380 Diagnostic Facilities
205.1390 Other Building Services
205.1400 Details and Finishes
205.1410 Construction, Including Fire-Resistive Requirements

SUBPART J: MECHANICAL

Section
205.1510 General
205.1520 Thermal and Acoustical Insulation
205.1530 Steam and Hot Water Systems
205.1540 Air Conditioning, Heating and Ventilating Systems

SUBPART K: PLUMBING AND OTHER PIPING SYSTEMS

Section
205.1610 General
205.1620 Plumbing Fixtures
205.1630 Water System
205.1640 Drainage Systems
205.1650 Identification

SUBPART L: ELECTRICAL

Section
205.1710 General
205.1720 Switchboards and Power Panels
205.1730 Panelboards
205.1740 Lighting
205.1750 Receptacles (Convenience Outlets)
205.1760 Grounding
205.1770 Equipment Installation in Special Areas
205.1780 Emergency Electric Service
205.1790 Fire Alarm System

TABLE A General Pressure Relationships and Ventilation Rates of Ambulatory Surgery Area

AUTHORITY: Implementing and authorized by the Ambulatory Surgical Treatment Center Act (Ill. Rev. Stat. 1981, ch. 111½, pars. 157-8.1 et seq.).

SOURCE: Amended July 18, 1974; emergency amendment at 3 Ill. Reg. 10, p. 43, effective February 23, 1979, for a maximum of 150 days; amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979; amended at 5 Ill. Reg. 12756, effective November 4, 1981; amended at 6 Ill. Reg. 6220, 6225, and 6226, effective May 17, 1982; amended at 6 Ill. Reg. 10974, effective August 30, 1982; amended at 6 Ill. Reg. 13337, effective October 20, 1982; amended at 7 Ill. Reg. 7640, effective June 14, 1983; codified at 8 Ill. Reg. 9367.

SUBPART A: GENERAL

Section 205.110 Definitions

"Ambulatory Surgical Treatment Center." The term ambulatory surgical treatment center shall have meaning as ascribed in the "Ambulatory Surgical Treatment Center Act" of 1973 as now and hereafter amended. (The Act) (Ill. Rev. Stat. 1979, ch. 111½, pars. 157-8.1 et seq.).

"Certified Registered Nurse Anesthetist" means a registered professional nurse who has been certified as a

nurse-anesthetist by the American Association of Nurse Anesthetists.

"Department" means the Department of Public Health of the State of Illinois.

"Licensed Practical Nurse" means a person licensed under The Illinois Nursing Act (Ill. Rev. Stat. 1979, ch. 111, par. 3401 et seq.) to practice practical nursing.

"Qualified Anesthesiologist" means a physician who is licensed to practice medicine in all its branches in the State of Illinois and who is a Diplomate of the American Board of Anesthesiology; or American College of Anesthesiology; or who is a Diplomate of the American Osteopathic Board of Anesthesiology; or who is Board eligible or possess training and experience equivalent to such eligibility; or who possess training and experience acceptable to the Department and whose primary practice is anesthesiology.

"Qualified Consulting Committee" means a committee whose members are qualified Surgeons, Obstetricians, Gynecologists, Anesthesiologists or Pathologists or other Consulting Physicians consisting of not less than 3 members who shall establish the required standards commensurate with the size, scope, extent and complexity of service programs and procedures for which the facility is licensed. The consulting committee shall act as the credentials committee.

"Qualified Consulting Surgeon, Obstetrician, Gynecologist, Anesthesiologist, Pathologist, or other Consulting Physician" means a physician who is licensed in the State of Illinois and who is a Diplomate of an appropriate specialty board or who has completed the training and experience required for specialty board certification.

"Qualified Physician" means an individual who is licensed to practice medicine in all branches in the State of Illinois.

"Qualified Dentist" means a dentist who is licensed to practice under the Dental Practice Act, (Ill. Rev. Stat. 1979, ch. 111, pars. 2202 et seq.).

"Qualified Podiatrist" means a podiatrist who is licensed to practice under "An Act to regulate the practice of

podiatry in the State of Illinois", (Ill. Rev. Stat. 1979, ch. 111, pars. 4901 et seq.).
"Registered Professional Nurse" means a registered nurse or a registered professional nurse who is registered under the Illinois Nursing Act (Ill. Rev. Stat. 1979, ch. 111, pars. 3401 et seq.), and practices professional nursing.
"Student Nurse" means a person enrolled in a course of instruction at an approved school of professional or practical nursing and who is supervised by a nursing instructor of the school.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.120 Licensure

a) An application for license shall be made to the Department on forms provided by it. This application shall contain the information required under the Act and this Part. The application shall be submitted not less than sixty (60) days prior to the date of intended operation.
b) The application shall include but not be limited to the following information:
   1) the name(s) and address(es) of person(s) who own and/or operate the facility and the name under which they do business. A corporation shall submit:
      A) a copy of its certificate of incorporation,
      B) list of the title, name, and address of each of its corporate officers,
      C) list of the name and address of each of its shareholders holding more than 5%, of the shares.
   2) location of the facility.
   3) description of the facility including but not limited to interviewing, examination, surgical, and recovery room facilities.
   4) schematic architectural plans.
   5) documentation of compliance with all applicable building, utility and Safety Codes.

   6) description of services to be provided by the facility including a list of surgical procedures to be performed.
   7) list of all personnel including their name, address, position, qualifications and licensure.
   8) All applications shall be signed by the applicant and the application shall include a verification form acknowledging the application to be true and complete and certifying that the applicant has knowledge of and understands the action required to comply with the Act and licensing requirements. The form shall be verified by a notary public. The forms shall be accompanied by a license fee of $500.
   9) As a condition of the issuance or renewal of the license of any Ambulatory Surgical Treatment Center:
      A) The applicant shall file a statement of ownership. The applicant shall agree to update the information required in the statement of ownership every 6 months from the initial date of filing,
      B) Each license shall file an attested financial statement with the Department by July 1, 1980 and at times thereafter as required,
      C) Financial statements shall be filed annually on or before April 1, of each year for the previous calendar year, or within three (3) months after the close of the fiscal period of the licensee,
      D) A financial statement shall be filed with the Department on forms provided by the Department or on annual financial statements prepared on forms used by the applicant. At minimum, they shall include detailed balance sheets, statements of income and statements of expense.
      E) Every facility licensed under this Act, and any premises proposed to be conducted as a facility by an applicant for a license shall

be open during its regular business hours to an inspection authorized in writing by the Director. No notice need be given to any person prior to any inspection,

F) Any corporation operating an Ambulatory Surgical Treatment Center devoted primarily to providing facilities for abortion must have a physician who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the center, on the Board of Directors as a condition to licensure of the center.

c) Only those facilities, services, programs and procedures included in the application shall be licensed. A new application is required for the following:
   1) change in ownership,
   2) change in location,
   3) remodeling of facility so as to change the interviewing, examination, surgical or recovery room space or number,
   4) addition of services or programs.

      AGENCY NOTE: The addition of new specialty services, for example, podiatry or obstetrics/gynecology, may require changes in consulting committee, procedures and/or staffing. Therefore, the Department finds that a new license is needed.

d) The license shall be valid for one (1) year, unless sooner suspended or revoked, shall be renewable annually upon approval by the Department and payment of a license fee of $300. Each license shall be issued only for the premises and persons named in the application and shall not be transferable or assignable. The licenses shall be posted in a conspicuous place on the licensed premises. A placard or registry of all physicians on staff in the facility shall be centrally located and available for inspection to any interested persons. The renewal application shall be on forms provided by the Department and shall be submitted to it not less than 30 days prior to the expiration date.

e) The facility shall give written notice to the Department within seven (7) days of any of the following:
   1) change of administrative staff,
   2) change of medical director,
   3) change of staff physicians,
   4) change of supervising nurse,
   5) addition or deletion of surgical procedures performed,
   6) in the case of a corporation change in any shareholders equity involving 5% or more interest.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

SUBPART B: OWNERSHIP AND MANAGEMENT

Section 205.210 Ownership, Control and Management
Ownership, control and management shall be disclosed at the time of application. The names and addresses of each person with financial interest in the facility shall be submitted to the Department.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.220 Organizational Plan
An organizational plan shall be known to the staff and available for public information in the facility. The document shall clearly set forth the organization, duties, responsibility, accountability and relationships of professional staff and other personnel. All owners, administrators, professional staff and ancillary personnel shall act in accordance with this document. This document shall be submitted to the Department with the initial application and thereafter will be reviewed at regular inspections by the Department.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.230 Standards of Professional Work
Management and/or the owner of the ambulatory surgical treatment center shall maintain proper standards of professional work in the licensed facility.

a) A qualified consulting committee shall be appointed in writing by the management and/or owner of the ambulatory surgical treatment center and shall establish and enforce standards for professional work in the facility and standards of competency for physicians. The consulting committee shall meet not less than quarterly and shall document all meetings with written minutes. These written minutes shall be maintained at the facility and shall be available for inspection by the Department.
   1) The membership of the consulting committee shall reflect the types of procedures performed. If the facility performs more than 50 procedures per month or more than 10% of the total procedures performed are in a specific speciality area then there shall be a consulting physician of that specialty on the consulting committee.
   2) The consulting committee shall review development and content of the written policies and procedures of the center, the procedures for granting privileges, and the quality of the surgical procedures performed. Evidence of such review shall be recorded in the minutes.
   3) Credentials shall be provided by those physicians seeking practice privileges. These credentials shall be reviewed by the credentials committee and specific practice privileges identified and recorded. Record of such accepted practice privileges shall be available for facility staff use and public information within the facility.
   4) A physician granted specific practice privileges shall provide evidence that he/she has equivalent practice privileges in at least one licensed Illinois hospital. Documentation of said evidence shall be available for inspection by the Department. A list of such privileges granted each physician on the staff of the ambulatory surgical treatment center shall be posted at all times for the staff of the center.

   5) The consulting committee shall act as a tissue committee and shall review at least quarterly pathological reports from procedures performed by each physician on the staff. Evidence of such review shall be recorded in the minutes.

b) A qualified physician shall be designated "Medical Director."
   1) The Medical Director shall secure compliance with the policies and procedures pertaining to medical and surgical procedures, approved by the consulting committee.
   2) The Medical Director shall medically supervise the professional personnel involved directly in the care of patients undergoing surgical procedures, including their preoperative and postoperative care and follow-up.
   3) The Medical Director shall establish and secure compliance of standards for the observation of patients by nursing personnel during the postoperative period.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.240 Policies and Procedures Manual

The management/owner of the ambulatory surgical treatment center shall formulate a written policies and procedures manual. This shall be done in cooperation with the medical and professional staff and shall be approved by the consulting committee. These procedures shall provide for the acceptance, care, treatment, anesthesia services, discharge, referral, and follow-up of all patients and all incidental operations of the facility. This manual shall be available to all staff in the center and shall be followed by them at all times in the performance of their duties.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

SUBPART C: PERSONNEL

Section 205.310 Personnel Policies
Each ambulatory surgical treatment center shall have written personnel policies including job descriptions for each staff position, which shall include minimum qualifications required for the position. There shall be a documented procedure for orientation of new employees to the facility's policies and procedures as well as the personnel policies including a copy of the appropriate job description.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.320 Presence of Qualified Physician
A qualified physician shall be present at the facility at all times during the operative and postoperative period for all patients.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.330 Nursing Personnel
At least one registered professional nurse with postgraduate education or experience in surgical nursing shall direct and supervise the nursing personnel and the nursing care of patients and shall be on duty at all times on the premises when patients are present.

Nursing care may be provided by student nurses and licensed practical nurses who have been trained in observation and emergency techniques for preoperative and postoperative care of surgical patients and who are under the direct personnel supervision of a registered nurse at all times.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.340 Basic Life Support
At least one person who is certified in "Basic Life Support" by the American Heart Association shall be on the premises while patients are present.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.350 Ambulatory Surgical Treatment Center
Each ambulatory surgical treatment center shall have one of the following:

a) a qualified medical technician who is certified by the American Society of Clinical Pathologists or is the holder of a letter, certificate, or record from the Bureau of Quality Assurance of the Department of Health, Education, and Welfare that he/she has passed the Federal Proficiency Examination Program for Clinical Laboratory Technologists, to perform required laboratory procedures.

b) A written agreement with a laboratory, licensed by the Department, to perform required laboratory procedures.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

SUBPART D: EQUIPMENT, SUPPLIES, AND FACILITY MAINTENANCE

Section 205.410 Equipment
Equipment shall be in good working order and shall be available in numbers sufficient to provide good patient care based on the procedures to be performed in the facility.

a) There shall be monitoring equipment, suction apparatus, oxygen and related items available within the surgical and postoperative recovery area. Cardiac pulmonary resuscitation equipment shall be available in all facilities.

b) There shall be written procedures governing the care, use, sterilization, storage and disposal of all materials to insure that an adequate supply of sterile equipment is available for each procedure. The section on "Sterilization and Disinfection" from Infection Control in the Hospital, most recent edition, American Hospital Association, shall be used as the guideline.

c) There shall be written procedures to assure safety in storage and use of inhalation anesthetics and medical gases. The current edition of the National

Fire Protection Association Code (Standard No. 56a) shall be used as the standard.

d) There shall be written procedures to assure the safety in storage and use of all narcotics and medications in accordance with state and federal law.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.420 Sanitary Facility

The ambulatory surgical treatment center shall insure maintenance of a sanitary facility with all equipment in good working order. Written procedures shall include provision for garbage and refuse removal, insect and rodent control, maintenance of water, heat, ventilation and air conditioning, and electrical service.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

SUBPART E: GENERAL PATIENT CARE

Section 205.510 Emergency Care

a) Each facility shall have a written plan of procedure to be followed in case of fire, explosion, or non-patient medical emergency. This plan shall specify persons to be notified and actions to be taken and shall be known by all staff of the facility.

b) Each facility shall be prepared to manage those emergencies which may be associated with procedures performed there.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.520 Preoperative Care

a) Where medical evaluation, examination, and referral are made from a private physician's office, hospital, or clinic, pertinent records thereof shall be available and made part of the patient's clinical record at the time the patient is registered and admitted to the ambulatory surgical treatment center.

b) A complete medical history shall be obtained and the physical examination shall be complete. A hemo-

globin or hematocrit and examination of the urine for sugar, protein, and acetone shall be performed by a qualified laboratory technician prior to the following procedures:

1) those performed with general anesthesia,
2) those performed with local anesthesia with sedation,
3) those performed to terminate pregnancy.

c) A written statement indicating informed consent and a signed authorization by the patient for the performance of the specific surgical procedure shall be procured and made part of the patient's clinical record.

d) Surgical procedures shall not be performed on patient's having medical, surgical, or psychiatric conditions or complications as specified by the consulting committee in the facility's written policies.

(Source: Amended at 6 Ill. Reg. 10974, effective August 30, 1982)

Section 205.530 Operative Care

a) Surgical procedures shall be performed only by a qualified physician, dentist or podiatrist within the limits of his/her defined specific practice privileges.

b) A qualified anesthesiologist, a dental anesthesiologist or a certified registered nurse anesthetist, medically directed by a licensed physician who administers or directs the administration of anesthesia in an Illinois licensed hospital, shall be present for the administration of anesthetics and recovery of patients when any general or major regional anesthetic is used.

c) All tissues removed during surgery shall be examined by a consulting pathologist and all x-rays shall be read by a consulting radiologist who shall provide a written report of his/her examination to the attending physician. A copy of this report shall be filed in the patient's clinical record within seven (7) days.

(Source: Amended at 6 Ill. Reg. 13337, effective October 20, 1982)

Section 205.540 Postoperative Care

a) Patients who have had general anesthesia, local anesthesia with sedation, or a pregnancy termination shall be observed in the facility for a period of time sufficient to ensure that no immediate postoperative complications are present. No patient shall be required to leave the center in less than one (1) hour following the procedures.

b) Patients in whom a complication is known or suspected to have occurred during or after the performance of a surgical procedure, shall be informed of such condition and arrangements made for treatment of the complication. In the event of admission to an inpatient facility a summary of care given in the ambulatory surgical treatment center concerning the suspected complication shall accompany the patient.

c) To insure availability of follow-up care at a licensed hospital, the ambulatory surgical treatment center shall provide written documentation of one of the following:
   1) A transfer agreement with a licensed hospital within approximately fifteen (15) minutes travel time of the facility.
   2) A statement that the medical director of the facility has full admitting privileges at a licensed hospital within approximately fifteen (15) minutes travel time and that he/she will assume responsibility for all facility patients requiring such follow-up care.
   3) A statement that each staff physician, dentist, or podiatrist has admitting privileges in a licensed hospital within fifteen (15) minutes travel time of the facility.

d) Written instructions shall be issued to all patients in accordance with the standards approved by the consulting committee of the ambulatory surgical treatment center and shall include the following:
   1) Symptoms of complications associated with procedures performed.

   2) Limitations and/or restrictions of activities of the patient.
   3) Specific telephone number to be used by the patient, at anytime, should any complication or question arise.
   4) A date for follow-up or return visit after the performance of the surgical procedure which shall be scheduled within six weeks.

e) Patients shall be discharged only on the written signed order of a physician.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

SUBPART F: RECORDS AND REPORTS

Section 205.610 Clinical Records

Accurate and complete clinical records shall be maintained for each patient and all entries in the clinical record shall be made at the time the surgical procedure is performed and when care, treatment, medications, or other medical services are given. The record shall include, but not be limited to, the following:

a) patient identification.
b) admitting information including patient history, physical examination findings, diagnosis or need for medical services.
c) pre-counseling notes.
d) signed informed consent.
e) confirmation of pregnancy (when abortion is performed).
f) signed physician orders.
g) laboratory test reports, pathologist's report of tissue, and radiologist's report of x-rays.
h) anesthesia record.
i) operative record.
j) medication and medical treatments.
k) recovery room progress notes.
l) physician and nurses' progress notes.
m) condition at time of discharge.

n) patient instructions.
o) post-counseling notes.
(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.620 Statistical Data
Each ambulatory surgical treatment center shall submit to the Department annually, clinical statistical data including the following:
a) the number and type of procedures performed.
b) the number and type of complications reported.
c) the number of patients requiring transfer to a licensed hospital for treatment of complications.
d) the number of patients returning for follow-up contact.
e) the number of deaths.
(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

SUBPART G: ADDITIONAL REQUIREMENTS FOR FACILITIES IN WHICH OBSTETRICAL/GYNECOLOGICAL PROCEDURES ARE PERFORMED

Section 205.710 Abortions
Abortions shall be provided to the public with the same standards of safety, effectiveness, and regard for patients rights as any other health service.
(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.720 Personnel
At least one registered professional nurse with postgraduate education or experience in obstetrical or gynecological nursing shall supervise and direct the nursing personnel and care of patients having obstetrical procedures.

AGENCY NOTE: Procedures involving the pregnant uterus are subject to particular complications and postoperative care requires a special knowledge on the part of nursing staff.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.730 General Patient Care
a) Examination
1) Prior to obstetrical procedures blood Rh factor shall be determined by a qualified laboratory technician for every patient.
2) The physician performing an abortion procedure shall establish the diagnosis of pregnancy by appropriate clinical evaluation and testing prior to performing an abortion procedure.
3) Time shall be allowed between the initial examination and termination of pregnancy to permit the reporting to and reviewing of all laboratory tests with the patient by the facility physician.
b) Counseling
1) Counseling shall be provided following disclosure to the patient of the diagnosis of pregnancy, and prior to performance of any surgical procedure. It shall be done individually and in a room designated for such use which shall not be the procedure room.
2) All facilities shall provide orientation training for counselors and insure that each counselor is qualified to:
A) Counseling shall be done by a person qualified to:
i) discuss alternatives for dealing with an unwanted pregnancy;
ii) describe the procedures used in the facility;
iii) explain the risks and possible complications of each procedure;
iv) provide contraception information.
B) Demonstration of such counseling qualifications shall be required by the Department.
C) Documentation of orientation training shall be required by the Department.
D) Counselors shall have no financial interest in the patient's decision.
3) Counseling shall include a discussion of alternatives, description of the procedure to be per-

formed, explanation of risks and possible complications. Contraceptive information may be provided postoperatively. Group counseling may be provided in addition to individual counseling. The patient's clinical record shall include documentation of the counseling received.

AGENCY NOTE: In the opinion of the Ambulatory Surgical Treatment Center Licensing Board, the patient should make a decision concerning the procedure in an atmosphere free from coercion. Consequently, the Board believes this is best accomplished in a room separate and apart from the procedure room. The Board believes that it is difficult to reach a truly voluntary decision while the patient is undressed and on the procedure table.

(Source: Amended at 5 Ill. Reg. 12756, effective November 4, 1981)

Section 205.740 Preoperative Requirements
Abortions may be performed in an ambulatory surgical treatment center on only those patients with gestation up to and including 12 weeks commencing with ovulation rather than computed on the basis of the menstrual cycle, as determined by the physician, if the patient's medical condition permits. Abortions shall not be performed in an Ambulatory Surgical Treatment center on those patients whose gestation exceeds 12 weeks.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.750 Postoperative Requirements

a) Each obstetrical/gynecological service shall provide Rh factor sensitization prophylaxis to all Rh negative patients according to standard medical procedures.
b) Information on availability of family planning services shall be provided, when desired by the patient. When, in the physician's opinion, it is in the best interest of the patient and with the patient's

consent, family planning services may be initiated prior to the discharge of the patient.

(Source: Amended at 5 Ill. Reg. 12756, effective November 4, 1981)

Section 205.760 Reports

a) A report of each abortion procedure performed in an ambulatory surgical treatment center shall be made to the Department on forms provided by it. These reports shall be submitted not later than ten (10) days following the month in which the abortion was performed. Reports shall be submitted on procedures performed whether or not the patient was pregnant.
b) Reports shall not be filled out in such a manner or at such a time as to avoid accurate reporting of complications.
c) If the facility becomes aware of a complication following the submission of the original report, then a supplemental report shall be submitted to the Department.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

SUBPART H: PROCEDURES FOR INVESTIGATION OF COMPLAINTS

Section 205.810 Complaints
All complaints against ambulatory surgical treatment centers shall be reported to the Illinois Department of Public Health. Complaints should preferably be in writing and contain sufficient facts to facilitate the investigation. Complaints by telephone will be accepted. Complaints will be required in writing if needed to support legal action against applicant.

(Source: Amended at 6 Ill. Rev. 6220, effective May 17, 1982)

Section 205.820 Acknowledgement of Complaint
Upon receipt of each complaint the Department will, with-

in seven (7) days, acknowledge by letter receipt of the complaint.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.830 Investigation

If the complaint contains allegations which, if true, would constitute a prima facie violation of the Ambulatory Surgical Treatment Center Act or this Part an investigation will be conducted. Whenever the complaint concerns matters outside the jurisdiction of the Department of Public Health, or may concern matters which are within the jurisdiction of another agency, the complaint also will be referred to the appropriate agency whenever so doing does not violate patient confidentiality.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.840 Prompt Investigation

The Department will promptly investigate each complaint within thirty (30) days of receipt of the complaint. Complaints which constitute a threat to the public health will be investigated within ten (10) days of receipt of the complaint.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.850 Methods

The Department will utilize the most efficient and effective methods to investigate each complaint. This may include inspections pursuant to Section 9 of the Act and the issuance of subpoenas and subpoenas duce tecum pursuant to Section 7 of the Act, when appropriate.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.860 Notification of Results

Upon the conclusion of the investigation the complainant will be notified of the results of the investigation and any action taken by the Department.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

SUBPART I: BUILDING DESIGN, CONSTUCTION STANDARDS, AND PHYSICAL REQUIREMENTS

Section 205.1310 Plant and Service Requirements

All ambulatory surgical treatment centers are required to meet the following physical plant and service requirements.

a) All proposed facilities shall meet these requirements before licensure will be granted.

b) All existing facilities that are not in compliance with this Section, and subsequent Sections, shall come into compliance no later than May 17, 1984.

(Source: Amended at 7 Ill. Reg. 7640, effective June 14, 1983)

Section 205.1320 General Considerations

a) Location

This facility shall be identifiably separate from other facilities and functions.

b) Narrative Program

The sponsor for each project shall provide a narrative program of functions for the facility which contains space requirements, staffing patterns, departmental relationships and other basic information relating to the fulfillment of the institution's objectives. This may be a general or detailed description of each function to be performed, space needed for these functions, hours of operation, number of staff or other occupants of the various spaces, types of equipment required, interrelationship of various functions and spaces, and description of those services necessary for the complete functioning of the facility but which are available elsewhere in the community and, therefore, need not be duplicated in this facility. Explain the type of surgery or procedures, the volume of work, the number of doctors, etc.

c) Size

The extent (number and types) of the diagnostic, clinical, and administrative facilities to be provided shall be determined by the services contemplated

and the estimated patient load as described in the narrative program.

d) Provisions for the Handicapped
The design shall provide for accessibility to the physically handicapped (public, staff, and patients).

e) Privacy for Patient
The design of the facility shall provide for the privacy and dignity of the patient during interview, examination, and treatment.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1330 New Construction, Additions and Major Alterations

Requirements and procedures for new construction, additions, and major alterations are as follows:

a) Preliminary drawings and outline specifications whether for new construction or for substantial alterations, shall be submitted to the Department with a program narrative description for review and approval prior to starting final working drawings and specifications.

b) The final working drawings and specifications shall be submitted to the Department for review and approval prior to release of contract documents for bidding. Change orders which affect scope and/or function shall be submitted for approval prior to execution.

c) The Department shall be notified of the award of contracts, and when construction has been completed. Approval by the Department prior to occupancy is required.

d) The preparation and submission of drawings and specifications shall be executed by, or under the immediate supervision of an architect registered in the State of Illinois.

e) First stage submission. Design Development Drawings and Outline Specifications.

f) Development of the preliminary sketch plans indicating in detail the assignment of all spaces, size of areas and rooms, indicating in outline, the fixed and movable equipment and furniture.

1) The plans shall be drawn at a scale sufficiently large to clearly present the proposed design.
2) The drawings shall include:
   A) a plan of each floor including the basement or ground floor,
   B) plan showing roads, parking areas, sidewalks, etc.,
   C) elevations of all facades,
   D) sections through the building,
   E) and all adjacent areas clearly labeled if addition or alteration.
3) The total gross floor area shall be shown on the drawings.
4) Outline specifications shall provide a general description of the construction including finishes; acoustical material, its extent and type; heating and ventilating systems; and the type of elevators.
5) A brief narrative of the proposed program.

g) Second stage submission. Working Drawings and Specifications.
All working drawings shall be well prepared so that clean and distinct prints may be obtained; be accurately dimensioned and include all necessary explanatory notes, schedules and legends. Working drawings shall be complete and adequate for contract purposes. Separate drawings shall be prepared for each of the following branches of work: Architectural, Structural, Mechanical, Electrical. They shall include or contain the following:

1) Architectural Drawings.
   A) Site plan showing all new topography, newly established levels and grades, existing structures on the site (if any), new buildings and structures, roadways, walks, and the extent of the areas to be landscaped. All structures and improvements which are to be removed under the construction contract shall be shown.
   B) Plan of each floor.
   C) Elevations of each facade.
   D) Sections through building.

E) If elevators and dumbwaiters are provided, drawings are required showing shaft details and dimensions, sizes of cab platforms and doors, travel distances including elevation height of landings, pit sizes, and machine rooms.

F) Special care areas, and similar areas shall be detailed at a scale to show the location, type, size and connection of all fixed and movable equipment.

G) Schedule of finishes.

2) Structural Drawings.

A) Plans of foundations, floors, roofs and all intermediate levels shall show a complete design with sizes, sections, and the relative location of the various members. Schedule of beams, girders and columns.

B) Floor levels, column centers, and off-sets shall be dimensioned.

C) Special openings and pipe sleeves shall be dimensioned or otherwise noted for easy reference.

D) Details of all special connections, assemblies and expansion joints shall be given.

E) Notes on design data shall include the name of the governing building code, values or allowable unit stresses, assumed live loads, including wind loads, earthquake load, and soil bearing pressures.

3) Mechanical Drawings. The drawings with specifications shall show the complete heating, cooling and ventilation systems; plumbing, drainage, stand pipe, and sprinkler systems.

A) Heating, Cooling and Ventilation.

i) Any radiators, coils and steam heated equipment, such as sterilizers.

ii) Heating and steam mains and branches with pipe sizes.

iii) Diagram of heating and steam risers with pipe sizes.

iv) Sizes, types and heating surfaces of boilers, furnaces, with stokers and oil burners, if any.

v) Pumps, tanks, boiler breeching and piping and boiler room accessories.

vi) Air conditioning systems with required equipment, water and refrigerant piping, and ducts.

vii) Supply and exhaust ventilating systems with connections and piping.

viii) Air quantities for all room supply and exhaust ventilating duct openings.

B) Plumbing, Drainage and Stand Pipe Systems.

i) Size and elevation of: street sewer, house sewer, house drains, street water main and water service into the building.

ii) Location and size of soil, waste, and vent stacks with connections to house drains, cleanouts, fixtures and equipment.

iii) Size and location of hot, cold and circulating mains, branches, and risers from the service entrance, and tanks.

iv) Riser diagram of all plumbing stacks with vents, water risers and fixture connections.

v) Any gas, oxygen and similar piped systems.

vi) Any standpipe and sprinkler systems.

vii) All fixtures and equipment that require water and drain connections.

4) Electrical Drawings. Drawings shall show all electrical wiring, outlets, and equipment which require electrical connections.

A) Electrical service entrance with switches and feeders to the public service feeders, characteristics of the light and power current, transformers and their connections if located in the building.

B) Location of main switchboard, power panels, light panels and equipment. Feeder and conduit sizes shall be shown with schedule of feeder breakers or switches.
C) Light outlets, receptacles, switches, power outlets, and circuits.
D) Telephone layout showing service entrance, telephone switchboard, strip boxes, telephone outlets and branch conduits as approved by the telephone company. Where public telephones are used for inter-communication, provide separate room and conduits for racks and automatic switching equipment as required by the telephone company.
E) Fire alarm system with stations, signal devices, control board and wiring diagrams.
F) Emergency electrical system with outlets, transfer switch, source of supply, feeders, and circuits as required by the approved program as required under the electrical part of these Standards.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1340 Minor Alterations and Remodeling Changes

Minor alterations and remodeling changes which do not affect the structural integrity of the building, or change functional operation, or which do not affect safety, need not be submitted for prior approval.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1350 Administration Department and Public Areas

Administration Department and Public Areas are facilities to be provided when indicated by the approved program.

a) The entrance shall be sheltered from the weather, located by grade level and must be able to accommodate wheelchairs and stretchers, if applicable.

b) The lobby shall include, if indicated by the approved program for the facility, the following:
   1) wheelchair and cart storage
   2) reception and information counter
   3) waiting area
   4) public toilets
   5) public telephones
   6) drinking fountain
c) Interview spaces for private interviews relating to social services, credit, and admissions shall be provided.
d) Adequate office space for records, business, meeting, and staff shall be provided.
e) A multipurpose room for conferences, and health education purposes including provisions for showing visual aids shall be provided if required by the program.
f) Storage spaces shall be provided for:
   1) office supplies
   2) sterile supplies, medical/surgical supplies and equipment
   3) pharmaceutical supplies
   4) housekeeping supplies and equipment

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1360 Clinical Facilities

a) Examination room(s)
   1) Each examination room(s) shall have a minimum clear floor area of 80 square feet, and a minimum dimension of 8 feet, excluding such spaces as vestibule, toilet, closet, and work counter (whether fixed or movable). Arrangements shall permit at least 2'-6" clearance at each side and at both ends of the examination table.
   2) A lavatory or sink equipped for handwashing with knee or foot control shall be provided.
   3) A counter or shelf space for writing shall be provided.

b) Procedure room(s)
   1) Provide at least one procedure room with a minimum clear area of 250 square feet and a minimum dimension of 14 feet, exclusive of fixed and movable cabinets and shelves. Any other procedure rooms shall not be less than 120 square feet with a minimum dimension of 10 feet.
   2) Provide a communication system connecting with the control station.
   3) Provide special features such as x-ray film illuminators, and storage space as required by the program.

c) Recovery room(s)
   1) Room(s) for post-anesthesia recovery for surgical patients shall be provided.
   2) Recovery room(s) shall contain a minimum of 100 square feet of usable floor space for single bed occupancy and at least 80 square feet per bed for multiple bed occupancy, so arranged that there will be at least 3 feet between beds and 4 feet of clear space at the foot of each bed.
   3) This room(s) shall contain a drug distribution station, handwashing facility, charting facilities, nurses' station, and storage space for supplies and equipment.
   4) Provide a toilet which is accessible to the recovery room, without having to leave the recovery room to reach it. The water closet shall be equipped with a gray diverter valve.
   5) A separate supervised room may be provided for use by patients who are able to leave the recovery (post-anesthesia) room but need additional time for all vital signs to be stabilized to the point where the patient may leave the facility. This room shall be equipped with reclining or lounge type chairs for patients and shall contain a minimum of 50 square feet of usable floor space for each patient to be accommodated at any one time.

   6) These recovery rooms may be combined, if desired.
   7) Provide a minimum of four recovery beds or lounge chairs for each procedure room. At least one of the four must be a bed, and the other three may be lounge chairs or beds.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1370 Support Service Areas

a) A control station shall be located to permit visual surveillance of all traffic which enters the operating suite.

b) Provide sterilizing facility(ies) with high speed autoclave(s) conveniently located to serve all procedure rooms. Approved alternate provisions may be made for replacement of sterile instruments during surgery.

c) A drug distribution station shall be provided for storage and preparation of medication to be administered to patients.

d) Scrub stations with knee or foot or elbow actuated faucets shall be provided near the entrances to the procedure rooms. Scrub facilities shall be arranged to minimize splatter on nearby personnel or supply carts.

e) A soiled workroom for the exclusive use of the surgical suite staff shall be provided. The soiled workroom shall contain a work counter, sink equipped for handwashing, waste receptacle, and linen receptacle. This room may be used for cleaning anesthesia equipment.

f) Fluid waste disposal facilities shall be conveniently located with respect to the general procedure rooms.

g)
   1) A clean workroom or a clean supply room is required when clean materials are assembled within the surgical suite prior to use. A clean workroom shall contain a work counter, sink equipped for handwashing, and space for clean

and sterile supplies. A clean supply room shall be provided when the narrative program defines a system for the storage and distribution of clean and sterile supplies which would not require the use of a clean workroom.

2) An autoclave shall be incorporated into the clean workroom.

h) Anesthesia storage facilities shall be provided. Flammable anesthetics are prohibited.

i) Medical gas supply storage with space for reserve nitrous oxide and oxygen cylinders shall be provided, with all tanks properly secured.

j) Storage area for equipment and supplies used in surgical suite shall be provided.

k) Staff and personnel facilities shall be provided for male and female personnel (orderlies, technicians, nurses, and doctors) working within the surgical suite. The areas shall contain lounge, lockers, toilets, lavatories equipped for handwashing, and space for changing clothing. These areas shall be arranged to provide a one-way traffic pattern so that personnel entering from outside the surgical suite can change, gown, and move directly into the surgical suite. Space for removal of scrub suits and foot covers shall be designed so that personnel using it will avoid physical contact with clean personnel.

l) Provide change areas where patients can change from street clothing into hospital gowns in privacy, and be prepared for surgery. This shall include lockers, toilets, clothing change or gowning area(s), and space for the administration of medications.

m) Stretcher storage area shall be out of direct line of traffic.

n) Janitor's closet containing a floor receptor or service sink, and storage space for housekeeping supplies and equipment shall be provided exclusively for the surgical suite.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1380 Diagnostic Facilities

If the pre-admission evaluation tests are to be performed within the facility, the following services shall be provided.

a) Radiographic suite, if provided, shall contain the following:
   1) film processing area
   2) viewing and administration area
   3) film storage facilities
   4) toilet room with handwashing facilities, directly accessible from each fluoroscopy room without entering the general corridor area.
   5) dressing area with convenient access to toilets.

b) Laboratory suite shall contain the following minimum facilities:
   1) Laboratory work counter with sink and vacuum, and electric services.
   2) Lavatory or counter sink equipped for handwashing.
   3) Storage cabinet or closet.
   4) Specimen collection facilities equipped with a toilet and lavatory.
   5) Blood collection facilities shall have space for a chair and work counter.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1390 Other Building Services

a) Engineering service and equipment areas shall have sufficient space for equipment rooms for boilers, furnaces, mechanical equipment, and electrical equipment.

b) Waste processing services shall be provided for the sanitary storage and disposal of waste by incineration, mechanical destruction, compaction, containerization, removal, or by a combination of these techniques.

c) Storage rooms for building maintenance supplies and yard equipment shall be provided.

d) Janitor's closets shall be provided with a floor receptor or service sink.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1400 Details and Finishes

a) Minimum public corridor width shall be 5′-0″, except those corridors where patients are transported in stretchers or carts shall be 8′-0″.

b) The facility or section shall have at least two exits remote from each other. Other details relating to exits and fire safety shall be in accordance with Section 13 (Business Occupancy) of the latest edition of NFPA Standard 101 and the requirements outlined herein. These Standards govern where different from the code.

c) Items such as drinking fountains, telephone booths, vending machines, and portable equipment shall be located so as not to restrict corridor traffic or reduce the corridor width below the required minimum.

d) All doors to toilets which may be used by patients shall be equipped with hardware which will permit access in any emergency.

e) The minimum width of doors for patient access to examination and treatment rooms shall be 3′-0″.

f) The minimum width of doors to rooms needing access for stretchers (procedure rooms, recovery) shall be 3′-8″.

g) Doors on all openings between corridors and rooms or spaces subject to occupancy, except elevator doors, shall be swing type.

h) Doors, except doors to spaces such as small closets which are not subject to occupancy, shall not swing into corridors in a manner that might obstruct traffic flow or reduce the required corridor width.

i) Doors, sidelights, borrowed lights, and windows in which the glazing extends down to within 18 inches of the floor (thereby creating possibility of accidental breakage by pedestrian traffic) shall be glazed with safety glass, wire glass, or plastic glazing material that will resist breaking and will not create dangerous cutting edges when broken in accordance with the State of Illinois Safety Glazing Materials Act (Ill. Rev. Stat. 1981, ch. 111½, par. 3101 et seq.). Similar materials shall be used in wall openings unless required otherwise for fire safety.

j) Thresholds and expansion joint covers shall be made flush with the floor surface to facilitate use of wheelchairs and carts.

k) Air dryers, or paper towel dispensers and waste receptacles shall be provided at all handwashing fixtures.

l) Where labeled fire doors are required, these shall be certified by an independent testing laboratory as meeting the construction requirements equal to those for fire doors in National Fire Protection Association (NFPA) Standard 80. Reference to a labeled fire door shall be construed to include labeled frame and hardware.

m) Radiation protection requirements of X-ray and gamma ray installations shall conform to the requirements of the Department of Nuclear Safety Rules for Protection Against Radiation (32 Ill. Adm. Code, Subchapter b) and should follow guidelines of NCRP reports #33 dated February 1968, and #49 dated September 1976. Provisions shall be made for testing and completed installation before use, and all defects must be corrected before use.

n) The minimum ceiling height shall be 8′-0″, with the following exceptions:

1) Boiler rooms, if provided, shall have ceiling clearance not less than 2′-6″ above the main boiler header and connecting piping.

2) Radiographic and other rooms containing ceiling-mounted equipment and including those with ceiling-mounted surgical light fixtures shall have height required to accommodate the equipment and/or fixture.

3) Ceilings in corridors, storage rooms, toilet rooms, and other minor rooms may be not less than 7′-8″.

4) Suspended tracks, rails, and pipes located in path of normal traffic shall be not less than 6′-8″ above the floor.

o) Flammable Anesthetics are prohibited.

p) Cubicle curtains and draperies shall be noncombustible or rendered flame retardant and shall pass both the large and small scale tests of NFPA Standard 701.

q) Interior finish of walls and ceilings of all exit ways, storage rooms, and areas of unusual fire hazard shall have a flame spread rating of not more than 25.

r) Floor finish materials shall have a flame spread rating of not more than 75. If a separate underlayment is used with any floor finish material, the flame spread test assembly shall include the underlayment.

s) All interior finish materials shall have smoke developed rating of 450 or iess. The use of materials known to produce large amounts of toxic gases shall be avoided.

t) Floor materials shall be easily cleanable and have wear resistance appropriate for the location involved.
   1) In all areas frequently subject to wet cleaning methods, floor materials shall not be physically affected by germicidal and cleaning solutions.
   2) Floors that are subject to traffic while wet, shall have a nonslip surface.

u) Wall finishes shall be washable and in the immediate area of plumbing fixtures, shall be smooth and moisture resistant.

v) Floor and wall penetrations by pipes, ducts, and conduits shall be tightly sealed to minimize entry of rodents and insects. Joints of structural elements shall be similarly sealed.

w) Ceilings shall be cleanable and those in sensitive areas such as surgical rooms shall be readily washable and without crevices that can retain dirt particles. These sensitive areas shall have a finished ceiling, covering all overhead ductwork and piping.

x) Finished ceilings may be omitted in mechanical and equipment spaces, shops, general storage areas, and similar spaces, unless required for fire-resistive purposes.

y) Acoustical ceilings are recommended in corridors, multipurpose rooms, and waiting areas.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1410 Construction, Including Fire-Resistive Requirements

a) Buildings shall be of the following heights and construction types with automatic extinguishment system identified in the table below:

Construction Type	Stories 1	2	3	Over 3
2-hour Fire Resistive	X	X	X	X
1-hour Protected Noncombustible	X	X	X	
Noncombustible	X	X		
Heavy Timber	X	X*		
1-hour Protected Ordinary	X	X*		
1-hour Protected Wood Frame	X*			
Ordinary	X*			

Key:

X = Permitted types of construction.

* = Building requires automatic extinguishment protection except in procedure rooms. Smoke detectors must be installed in procedure rooms and all rooms not normally occupied (janitor's closet, storage, locker rooms, etc.).

b) Walls enclosing stairways, elevator shafts, chutes, and other vertical shafts, boiler rooms, and storage rooms (containing combustible materials) shall be of not less than one-hour fire resistive construction, except in buildings over 3 stories in height, where 2 hour enclosure is required.

c) Building insulation materials, unless sealed on all sides and edges, shall have a flame spread rating

of 25 or less and a smoke developed rating of 450 or less when tested in accordance with NFPA Standard 258.

d) Elevators and Dumbwaiters
   1) All ambulatory surgical treatment centers located above the first floor of the building shall have an electric or electrohydraulic elevator.
   2) Inspections and tests shall be made, and written certification be furnished, that the installation meets the requirements of all applicable safety regulations and codes.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

SUBPART J: MECHANICAL

Section 205.1510 General

a) Mechanical systems shall be tested, balanced, and operated to demonstrate that the installation and performance of these systems conform to the requirements of these Standards.

b) Upon completion of the contract, the owner shall be provided with a complete set of manufacturer's operating, maintenance and preventive maintenance instructions, and parts list with numbers and description for each piece of equipment. The owner shall also be provided with instruction in the operational use of the systems and equipment as required.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1520 Thermal and Acoustical Insulation

a) Insulation shall be provided for the following within the building:
   1) Boilers, smoke breeching and stacks.
   2) Steam supply and condensate return piping.
   3) Hot water piping above 180° F and all hot water heaters.
   4) Hot water piping above 125° F which is exposed to contact by patients.

   5) Chilled water, refrigerant, other process piping and equipment operating with fluid temperatures below ambient dew point.
   6) Water supply and drainage piping with fluid temperatures below ambient dew point.
   7) Air ducts and casings with outside surface temperatures below ambient dew point.
   8) Other piping, ducts, and equipment necessary to maintain the efficiency of the system.

b) Insulation may be omitted from hot water and steam condensate piping not subject to contact by patients when such insulation is unnecessary for preventing excessive system heat loss or excessive heat gain in the surrounding space.

c) Insulation on cold surfaces shall include an exterior vapor barrier.

d) Insulation, including finishes and adhesives on exterior surfaces of ducts, pipes, and equipment, shall have a flame spread rating of 25 or less and a smoke developed rating of 450 or less as determined by an independent testing laboratory in accordance with NFPA 255. Exception: Duct, pipe, and equipment coverings shall not be required to meet these requirements where they are located entirely outside the building, or do not penetrate a wall or roof or do not create an exposure hazard.

e) Linings in air ducts and equipment shall meet the Erosion Test Method described in UL Pub. No. 181. These linings, including coatings and adhesives, and insulation on exterior surfaces of pipes and ducts in building spaces used as air supply plenums, shall have a flame spread rating of 25 or less and a smoke developed rating of 450 or less as determined by an independent testing laboratory in accordance with NFPA 255.

f) Duct linings shall not be used in systems supplying procedure and recovery rooms unless terminal filters of at least 90 percent efficiency are installed downstream of the linings.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1530 Steam and Hot Water Systems

a) Boilers and/or hot water heaters shall have the capacity, based upon the net ratings published by the Hydronics Institute, to supply the normal requirements of all the systems and equipment.

b) Supply and return mains and risers of space heating and process steam systems shall be valved to isolate the various sections of each system. Each piece of equipment shall be valved at the supply and return ends.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1540 Air Conditioning, Heating and Ventilating Systems

a) The systems shall be designed to provide the comfort temperatures and humidities as recommended by ASHRAE Standards.

b) Air handling systems shall conform to "Installation of Air Conditioning and Ventilating Systems," NFPA 90A-1976.

c) For spaces not exceeding 25,000 cubic feet in volume, heating, air conditioning, and ventilating systems shall conform to "Standard for the Installation of Warm Air Heating and Air Conditioning Systems, NFPA 90-B, 1973, except return ducts shall be constructed of materials equal to that specified for supply ducts, Chap. 2, paragraph 1.1., Duct Materials.

d) Outdoor air intakes shall be located as far as practical but not less than 15 feet from exhaust outlets of ventilation systems, combustion equipment stacks, medical-surgical vacuum systems, plumbing vent stacks or from areas which may collect vehicular exhaust and other noxious fumes.

e) All ventilation air outlets and inlets shall conform to NFPA 90A-Chapter 2, paragraph 3.2. Location of Outlets and Inlets.

f) The ventilation systems shall be designed and balanced to provide the ventilation and pressure relationships as shown in Table A.

g) The ventilation air supplied to the procedure rooms shall be delivered at or near the ceiling of the area served, and all exhaust or return air from the area shall be removed near the floor level. At least two exhaust outlets shall be used in each procedure room.

h) All central ventilation or air conditioning systems shall be equipped with filters having efficiencies not less than those specified in the following table:

FILTER EFFICIENCIES FOR CENTRAL VENTILATION AND AIR CONDITIONING SYSTEMS IN AMBULATORY SURGICAL TREATMENT FACILITIES

Area Designation	Minimum Number of *Filter Beds*	Filter Efficiencies (Percent) Filter Bed *No. 1*	Filter Bed *No. 2*
Procedure and Recovery Rooms	2	25	90
All Other Areas	1	25	—

i) All filter efficiencies shall be average atmospheric dust spot efficiencies tested in accordance with the American Society of Refrigeration and Heating, Air Conditioning Engineers (ASHRAE) Standards 52-68.

j) For systems serving procedure and recovery rooms, filter bed No. 1 shall be located upstream of the conditioning equipment and filter bed No. 2 shall be located downstream of the supply fan and conditioning equipment including humidifiers.

k) Filter frames shall be durable and shall provide an airtight fit with the enclosing duct work. All joints between filter segments and enclosing duct work shall be gasketed or sealed to provide a positive seal against air leakage.

l) A manometer shall be installed across each filter bed serving procedure and recovery rooms.

m) Fire and smoke dampers shall be constructed, located and installed in accordance with the requirements of NFPA 90A.

n) All systems, regardless of size, which serve more than one smoke or fire zone, shall be equipped with smoke detectors to shut down fans automatically as specified in paragraph 4-3.1 of NFPA 90A.

o) The ventilation system for anesthesia storage rooms shall conform to the requirements of "Standard for Inhalation Anesthetics" NFPA 56A, including the gravity option ventilation system.

p) Boiler rooms shall be provided with sufficient outdoor air to maintain combustion rates of equipment and limit temperatures in working stations to 97° F Effective Temperature as defined by ASHRAE Handbook of Fundamentals.

q) Rooms containing heat-producing equipment, such as boiler rooms and heater rooms, shall be insulated and ventilated to prevent any floor surface above from exceeding a temperature of 100° F.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

SUBPART K: PLUMBING AND OTHER PIPING SYSTEMS

Section 205.1610 General

All plumbing systems shall be designed and installed in accordance with the requirements of the Illinois Plumbing Code (77 Ill. Adm. Code 890).

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1620 Plumbing Fixtures

a) Plumbing fixtures shall be of nonabsorptive acid-resistant materials.

b) The water supply spout, for lavatories and sinks required for filling pitchers, for medical and nursing staff handwashing, shall be mounted so that its discharge point is a minimum perpendicular distance of 5 inches above the rim of the fixture.

c) All fixtures for use by medical and nursing staff shall be trimmed with valves which can be operated without the use of hands.

1) When blade handles are used for this purpose, the blade handles shall not exceed 4½ inches in length.

2) The scrub sinks for surgery shall be trimmed with valves which are aseptically operated (i.e., knee or foot or elbow actuated) without the use of hands. Wrist blade handles are not acceptable.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1630 Water System

a) Water systems shall be designed to supply water at sufficient pressure to operate all fixtures and equipment during maximum demand periods.

b) Each water service main, branch main, riser, and branch to a group of fixtures shall be valved. Stop valves shall be provided at each fixture.

c) Approved backflow preventers or vacuum breakers shall be installed on hose bibbs, laboratory sinks, janitors' sinks, and on all other fixtures to which hoses or tubing are, or can be attached.

d) Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1640 Drainage Systems

a) Building sewers shall discharge into a community sewage system.

b) Where a community sewage system is not available, sewage and liquid wastes shall be collected, treated and disposed of in a private treatment system which must conform to local and State regulations.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1650 Identification
All piping for, heating, ventilating and air conditioning, and service water systems shall be coded and marked for easy identification.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

SUBPART L: ELECTRICAL

Section 205.1710 General

a) All material including equipment, conductors, controls, and signaling devices shall be installed to provide a complete electrical system with the necessary characteristics and capacity to supply the required electrical facilities. All materials shall be listed as complying with available standards of Underwriters' Laboratories, Inc., or other similarly established standards.

b) All electrical installations and systems shall be tested to show that the equipment is installed and operates as required. A written record of performance tests on special electrical systems and equipment shall be supplied to the owner. Such tests shall show compliance with the governing codes and shall include grounding continuity and alarm systems.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1720 Switchboards and Power Panels
Circuit breakers or fusible switches that provide disconnecting means and overcurrent protection for conductors connected to switchboards and panelboards shall be enclosed or guarded to provide a dead-front type of assembly.

a) The main switchboard shall be located in a separate enclosure accessible only to authorized persons.

b) The switchboards shall be convenient for use, readily accessible for maintenance, clear of traffic lanes, and in a dry ventilated space free of corrosive fumes or gases.

c) Overload protection devices shall be suitable for operating properly in the ambient temperature conditions.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1730 Panelboards
Panelboards serving lighting and appliance circuits shall be located on the same floor as the circuits they serve. This requirement does not apply to any emergency system circuits.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1740 Lighting

a) All spaces occupied by people, machinery, and equipment within buildings, approaches to the buildings, and parking lots shall have lighting.

b) A portable or fixed examination light shall be provided in each examination and treatment room.

c) Procedure rooms shall have general lighting, in addition to local lighting provided by adequate lighting units at the procedure tables. Each lighting unit at the tables, except for portable units, shall be connected to an independent circuit.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1750 Receptacles (Convenience Outlets)

a) Duplex grounding type receptacles shall be installed in all areas or rooms in sufficient quantities for the tasks to be performed.

b) A minimum of one duplex receptacle for each wall shall be installed in each work area or room, other than storage or locker rooms.

c) A minimum of two duplex receptacles shall be located convenient to each examination and work table.

d) Duplex receptacles for cleaning equipment and general use shall be installed approximately 50'0" apart in all corridors and within 25'0" of ends of corridors.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1760 Grounding
In areas used for patient care or treatment, all receptacles operating at over 100 volts, shall be grounded by an insulated copper conductor, sized in accordance with Table 250-95 of the 1975 National Electrical Code, and installed with the branch conductors supplying these receptacles.
(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Standard 205.1770 Equipment Installation in Special Areas
a) X-ray Installations. Fixed and mobile X-ray equipment installations, if installed, shall conform to Article 660 of NFPA Standards 70, 1975 Edition.
b) Installation in non-flammable anesthetizing locations of all electrical equipment and devices, receptacles, and wiring shall comply with NFPA Standard 70, 1975 Edition. Exception: Isolated electrical systems are not required.
(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1780 Emergency Electric Service
a) An emergency source of electricity shall be provided and connected to certain circuits for lighting to provide electricity during an interruption of the normal electric supply.
b) The source of this emergency electric service shall be a generator set, storage batteries or unit equipment as described in Art. 700-6 NFPA Standard 70.
c) Emergency electric service shall be provided to the following:
1) Illumination of means of egress as required in NFPA Standard 101.
2) Illumination for exit signs and exit directional signs as required in NFPA Standard 101.
3) Alarm systems including fire alarms activated at manual stations, water flow alarm devices of sprinkler system if electrically operated, fire and smoke detecting systems, and alarms required for nonflammable medical gas systems if installed.

4) General illumination and selected receptacles in the vicinity of the generator set, if installed.
5) Illumination in procedure and recovery room.
6) If 110 volt equipment will be utilized to maintain heart action, breathing, to control bleeding or other essential functions, receptacles connected to emergency power sources shall be installed.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1790 Fire Alarm System
A manually operated electrically supervised fire alarm system shall be installed in each facility.
(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205. TABLE A General Pressure Relationships and Ventilation Rates of Ambulatory Surgery Area

Within Area Room Units Designation	Pressure Relationship to Adjacent Areas	Minimum Total Air Changes per Hour Supplied to Room	All Air Exhausted Directly to Outdoors	Recirculated
Procedure Room	+	15	Optional	No
Examination Room	0	6	Optional	Optional
Recovery Room	+	6	Optional	Optional
Medication Area	+	4	Optional	Optional
X-Ray Room	0	6	Optional	Optional
Soiled Workroom or Soiled Holding	-	10	Yes	No
Clean Workroom or Clean Holding	+	4	Optional	Optional
Darkroom	-	10	Yes	No
Toilet Room	-	10	Yes	No
Janitors' Closet	-	10	Yes	No
Sterilizer Equip. Rm.	-	10	Yes	No
Linen and Trash Rm.	-	10	Yes	No
Laboratory	-	6	Optional	Optional
Soiled Linen Storage	-	10	Yes	No
Clean Linen Storage	+	2	Optional	Optional
Anesthesia Storage	0	8	Yes	No
Central Services Area				
Soiled Area	-	6	Yes	No
Clean Area	+	4	Optional	Optional
Equipment Storage	0	2	Optional	Optional

\+ = Positive
\- = Negative
0 = Equal

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

MOTION

No. 88-790 (3)

Supreme Court, U.S.
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In The
Supreme Court of the United States
October Term, 1988

BERNARD J. TURNOCK, M.D., M.P.H.,
Director of the Illinois Department
of Public Health, *et al.*,

Appellants,

v.

RICHARD M. RAGSDALE, M.D., *et al.*,

Appellees.

On Appeal From the United States
Court of Appeals For the Seventh Circuit

MOTION TO DISMISS OR AFFIRM

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32 pp

QUESTION PRESENTED

Whether the Court of Appeals correctly affirmed a preliminary injunction, based on factual findings entered after an expedited hearing, prohibiting the enforcement against plaintiffs of three Illinois statutes intended to restrict the performance of early abortions to "the functional equivalent of small hospitals," and which the Court of Appeals found burdened the abortion right without any "medical justification whatsoever"?

PARTIES TO THE PROCEEDINGS

(See Jurisdictional Statement)*

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* Pursuant to Rule 28.1 of the Supreme Court Rules, plaintiffs state that the Northern Illinois Women's Center is a medical corporation wholly owned by Richard Ragsdale, M.D., and has no parent, no subsidiaries and no affiliate corporations.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED.	i
PARTIES TO THE PROCEEDINGS.	ii
TABLE OF CONTENTS	iii
TABLE OF AUTHORITIES.	v
OPINIONS BELOW.	1
CONSTITUTIONAL, STATUTORY AND REGULATORY PROVISIONS INVOLVED. . .	1
STATEMENT OF THE CASE.	2
REASONS FOR DISMISSING THE APPEAL OR IN THE ALTERNATIVE AFFIRMING THE JUDGMENT BELOW	5
I. THIS COURT LACKS MANDATORY JURISDICTION AND SHOULD NOT EXERCISE ITS DISCRETIONARY JURISDICTION TO REVIEW THIS AFFIRMANCE OF A PRELIMINARY INJUNCTION ORDER WITHOUT A FULL AND FINAL RESOLUTION OF ALL FEDERAL ISSUES BY THE LOWER FEDERAL COURTS	5

II. NO ISSUES OF EXCEPTIONAL IMPORTANCE ARE PRESENTED FOR REVIEW. 8

A. The Court Of Appeals' Decision Replicates Recent Decisions Of This Court And Is In Accord With Decisions Of Other Courts Of Appeals That Have Enjoined Regulatory Schemes That Burden The Abortion Right. 8

B. The Court Of Appeals Correctly Applied Legal Standards Established By This Court For Review Of Provisions Affecting The Fundamental Right Of Abortion During The Early Stages Of Pregnancy 11

C. The Decision Below Is Consistent With This Court's Decisions In The Areas Of Justiciable Controversies And Severability . 18

1. In Light Of Defendants' Continuing Policy Of Enforcement, The Court Of Appeals Appropriately Affirmed The Preliminary Injunction. 18

2. The Court Of Appeals Properly Enjoined The Entire Regulatory Scheme As It Applies To Early Abortion Services 20

CONCLUSION 22

TABLE OF AUTHORITIES

Cases: *Pages*

Abortion Coalition of Michigan, Inc. v. Michigan Dep't of Public Health, 426 F. Supp. 471 (E.D. Mich. 1977) 10

Alabama State Federation of Labor v. McAdory, 325 U.S. 450 (1945) 19

Baird v. Department of Public Health, 599 F.2d 1098 (1st Cir. 1979) 11

Birth Control Centers, Inc. v. Reizen, 508 F. Supp. 1366 (E.D. Mich. 1981), *aff'd in part, vacated in part*, 743 F.2d 352 (6th Cir. 1984) . . 10

Birth Control Centers, Inc. v. Reizen, 743 F.2d 352 (6th Cir. 1984) 9, 10

Buckley v. Valeo, 424 U.S. 1 (1976) (*per curiam*) 21

Champlin Refining Co. v. Corporation Commission, 286 U.S. 210 (1932) 21

Charles v. Daley, 749 F.2d 452 (7th Cir. 1984), *appeal dism'd sub nom., Diamond v. Charles*, 476 U.S. 54 (1986). 19

C.I.O. v. McAdory, 325 U.S. 472 (1945). 19

City of Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416 (1983) 8, 10, 11, 12, 17

City of Los Angeles v. Lyons, 461 U.S. 95 (1983). 19

City of Mesquite v. Aladdin's Castle, Inc., 455 U.S. 283 (1982). 19

Connecticut v. Menillo, 423 U.S. 9 (1975) (*per curiam*) 11

Doe v. Bolton, 410 U.S. 179 (1973) 4

Ex Parte Young, 209 U.S. 123 (1908) 20

Fox Valley Reproductive Health Care Center, Inc. v. Arft, 446 F. Supp. 1072 (E.D. Wis. 1978) 9

Friendship Medical Center, Ltd. v. Chicago Bd. of Health, 505 F.2d 1141 (7th Cir. 1974), *cert. denied*, 420 U.S. 997 (1975) 9

Green v. Mansour, 474 U.S. 64 (1985) 20

Hodgson v. Lawson, 542 F.2d 1350 (8th Cir. 1976) (*per curiam*) 10, 11

Hodgson v. Lawson, No. 4-74-155 (D. Minn., March 7, 1977) 11

Indiana Hospital Licensing Council v. Women's Pavilion, 420 N.E.2d 1301 (Ind. App. 1981). . . 9

J.N.S. v. State of Indiana, 712 F.2d 303 (7th Cir. 1983) 19

Mahoning Women's Center v. Hunter, 610 F.2d 456 (6th Cir. 1979), *vacated on other grounds*, 447 U.S. 918 (1980) (mem.). 9, 21

Minneapolis Star & Tribune Co. v. Minn. Comm'r of Revenue, 460 U.S. 575 (1983) 17

Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976). 11, 14

Poe v. Ullman, 367 U.S. 497 (1961) 19

Ragsdale v. Turnock, 625 F. Supp. 1212 (N.D. Ill. 1985), *aff'd in part, vacated in part*, 841 F.2d 1358 (1988). 10

Ragsdale v. Turnock, 841 F.2d 1358 (7th Cir. 1988) . . . . . *passim*

Regan v. Time, Inc. 468 U.S. 641 (1984). 21

Roe v. Wade, 410 U.S. 113 (1973) 10, 11, 12, 17

Simopoulos v. Virginia, 462 U.S. 506 (1983) . . 10

Socialist Labor Party v. Gilligan, 406 U.S. 583 (1972). 7

Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747 (1986) 5, 7, 8, 12, 13, 16

United States v. Carolene Products Co., 304 U.S. 144 (1938) 6

Watkins v. Blinzinger, 789 F.2d 474 (7th Cir. 1986), *cert. denied*, ___ U.S. ___ 107 S. Ct. 1976 (1987). 20

Westchester Women's Health Organization, Inc. v. Whalen, 475 F. Supp. 734 (S.D.N.Y. 1979). 11

Wisconsin v. Yoder, 406 U.S. 205 (1972) 6, 17

CONSTITUTIONAL PROVISIONS

U.S. Const. Amend. I . . . . . *passim*

U.S. Const. Amend. IV. . . . . *passim*

U.S. Const. Amend. V . . . . . *passim*

U.S. Const. Amend. IX. . . . . *passim*

U.S. Const. Amend. XI. . . . . *passim*

U.S. Const. Amend. XIV, Section 1 . . . . . *passim*

STATUTES

28 U.S.C. Section 1254(2). 5, 6, 18

Ambulatory Surgical Treatment Center Act, Ill. Rev. Stat. ch. 111 1/2, par. 157-8.1 *et seq.* (1983). . . . . *passim*

Medical Practice Act, Ill. Rev. Stat. ch. 111 par. 4433 (1983). . . . . *passim*

Health Facilities Planning Act, Ill. Rev. Stat. ch. 111 1/2, par. 1151 *et seq.* (1983). . . . . *passim*

REGULATIONS

Ambulatory Surgical Treatment Center Licensing Requirements, 77 Ill. Adm. Code, Chapter 1, Subchapter b, Part 205. . . . . *passim*

OPINIONS BELOW

(See Jurisdictional Statement)

CONSTITUTIONAL, STATUTORY AND REGULATORY PROVISIONS INVOLVED

(See Jurisdictional Statement)

MOTION TO DISMISS OR AFFIRM

The United States Court of Appeals for the Seventh Circuit affirmed a preliminary injunction prohibiting the enforcement against plaintiffs of Illinois laws that operate together to require that all first and early second trimester abortions be performed in specially licensed facilities that are "'the functional equivalent of small hospitals.'" App. 19 (citation omitted). The Court of Appeals based its decision on District Court factual findings that the challenged statutes burdened the abortion right without any "medical justification whatsoever." App. 29.

The interlocutory decision below is not a final order subject to review under this Court's mandatory appeal jurisdiction. Review under a writ of certiorari also is inappropriate. The Court of Appeals' decision adheres closely to, and to a great extent replicates, prior Supreme Court decisions. Defendants offer no reason to disturb this precedent. Nor do defendants present any conflict or important federal question that warrants the Court's consideration at this interlocutory juncture.

STATEMENT OF THE CASE

As the courts below found, the challenged statutes are directed at providers of abortion services and are, in large part, intended to restrict abortion services. App. 21. As drafted, the Ambulatory Surgical Treatment Center Act ("ASTC Act") requires special licensure of all ASTCs, which, by definition, include "any . . . place or building devoted primarily to . . . the performance of surgical procedures" and "*any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose. . . .*" Ill. Rev. Stat. ch. 111 1/2, § 157-8.3(A) (emphasis added)[1].

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[1] The ASTC Act provides that failure to obtain an ASTC license constitutes a business offense punishable by a fine of $10,000 per day. *Id.* at § 157-8.12. Section 16-1 of the Medical Practice Act ("MPA"), Ill. Rev. Stat. ch. 111, § 4433(1), provides the second link of the scheme and grants employees of the Illinois Department of Registration and Education ("DRE") "absolute prosecutorial discretion" (Defendant's Jurisdictional Statement at 10) to revoke or suspend the license of any physician who performs even one first trimester abortion outside of a hospital or licensed ASTC. The Health Facilities Planning Act ("HFPA"), Ill. Rev. Stat. ch. 111 1/2, § 1151 *et. seq.*, provides the final link and requires ASTCs, like hospitals, to submit to the lengthy public hearings and potential public veto of the certificate of need ("CON") process prior to constructing, renovating, or relocating their facilities.

References to defendants' Jurisdictional Statement appear as "Juris. St." References to the Court of Appeals' opinion and other documents from defendants' Appendix to Jurisdictional Statement appear as "App." References to the trial transcript appear as "Tr." or "Dep."

The ASTC Act does not single out any type of surgical procedure, other than abortion, for special regulation. While defendants posit benevolent "general" health regulations, applied even-handedly to all health care providers (Juris. St. 24-25), such a regulatory scheme simply is not at issue here.

The trial court below concluded, as a matter of fact, and the Court of Appeals affirmed as not clearly erroneous, that the tripartite regulatory scheme burdened, without medical justification, the rights of women to choose to have first and early second trimester abortions. The challenged statutes drive up the cost of each abortion procedure; substantially impede women who seek access to abortion services; and prevent potential health care providers from offering abortions because the cost of compliance is "prohibitive." App. 22-23, 31. Defendants failed to supply any evidence that the statutory provisions either enhanced the safety of early abortion procedures or protected the pregnant woman's health. App. 29-30. Indeed, rather than "protect[ing] public health" (Juris. St. 5), the challenged scheme actually proved to be harmful, from a medical standpoint, for some women seeking abortions. App. 27-28.

Thus, the Court of Appeals affirmed the District Court's preliminary injunction, applying established Supreme Court precedent, which directs that when a state statute, whether abortion-neutral or abortion-specific, burdens the exercise of a woman's decision to have an abortion, that statute can withstand constitutional scrutiny only if it is justified by a compelling governmental interest and is carefully crafted to advance that interest. In addition, the Court of Appeals indicated that this scheme lacked even a reasonable basis. App. 24.

Defendants' contention that the decision below "has exempted outpatient surgical facilities in which abortions are performed from general licensure and regulatory provisions" (Juris. St. 21) is belied by the express terms of the injunction issued. Contrary to defendants' claim that the decision below "emasculates" the State's general authority to regulate physicians or outpatient medical facilities (Juris. St. 21), the injunction left the defendants free to apply their regulatory scheme to non-abortion medical procedures, even when abortion and non-abortion procedures are performed in the same facility. App. 110-11. The State also remains free to enforce against physicians who perform abortions the professional censure and licensing provisions of the MPA, for with the exception of Section 16-1, which requires abortions to be performed in ASTCs, the MPA was not challenged. *Compare Doe v. Bolton*, 410 U.S. 179, 200 (1973). Further, even facilities exclusively devoted to abortion practice remain subject to general state and local safety regulations such as fire and building codes.

Thus the courts below preliminarily enjoined the challenged statutory scheme, but did so only insofar as necessary to protect the constitutional rights of women seeking first and early second trimester abortion procedures.

REASONS FOR DISMISSING THE APPEAL OR IN THE ALTERNATIVE AFFIRMING THE JUDGMENT BELOW.

I. THIS COURT LACKS MANDATORY JURISDICTION AND SHOULD NOT EXERCISE ITS DISCRETIONARY JURISDICTION TO REVIEW THIS AFFIRMANCE OF A PRELIMINARY INJUNCTION ORDER WITHOUT A FULL AND FINAL RESOLUTION OF ALL FEDERAL ISSUES BY THE LOWER FEDERAL COURTS.

In their attempt to attract this Court's attention under its waning mandatory jurisdiction, defendants overlook a fundamental prerequisite to the exercise of such jurisdiction. Under 28 U.S.C. § 1254(2), Supreme Court jurisdiction exists only to review a final judgment by the court of appeals declaring a state statute invalid as repugnant to the Constitution. *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 754-755 (1986).

In this case, the District Court held its hearing on an expedited basis in response to plaintiffs' plea that preliminary injunctive relief issue before the threatened termination of Dr. Ragsdale's medical practice when his lease expired on December 31, 1985. (Juris St. 5); App. 118. As defendants themselves acknowledge, the injunction the Court of Appeals affirmed was preliminary in nature. (Juris. St. 1, 14, 16.) This interlocutory judgment is not a final judgment within "the ordinary meaning of that term." *Thornburgh*, 476 U.S. at 754 (dismissing state appeal of

preliminary injunction of abortion law). Thus, defendants' attempt to invoke this Court's mandatory jurisdiction is premature.

The concerns about premature review which underlie the finality requirement of § 1254(2) further caution against the grant of a writ of certiorari to review this preliminary injunction. Although plaintiffs filed suit on behalf of a class of physicians and a class of Illinois women, the preliminary injunction hearing focused primarily on Dr. Ragsdale's need for immediate relief. (Tr. 20.) The District Court made clear that, given the emergency nature of Dr. Ragsdale's case, it was conducting only a "preliminary injunction hearing and not a final injunction [hearing]." (Tr. 622.) The Court, as well as the parties, anticipated that a more complete evidentiary record would be made at a future permanent injunction hearing. (*See* Tr. 20, 531, 622.)

Nowhere is the need for such factual development more important than in the adjudication of fundamental rights, such as the right to privacy. *See United States v. Carolene Products Co.*, 304 U.S. 144, 152 n.4 (1938); *see generally Wisconsin v. Yoder*, 406 U.S. 205, 209-213 (1972). Further fact-finding may have a profound impact upon the rulings made by the lower federal courts on the constitutionality of the Illinois statutes and thereby sharpen the presentation of the ultimate issues should the case come before this Court at some future date.

In addition, as shown below, the Court of Appeals' decision follows closely the directives of this Court with regard to regulation of early abortion services. As a result, defendants cannot support their contention that this case presents issues important enough to warrant review at this

stage. Review by this Court now would be limited to the question of whether the preliminary injunction constituted an abuse of the District Court's discretion and whether the District Court's factual findings, subject to change based on future factual development, were clearly erroneous.[2]

"Problems of prematurity and abstractness may well present 'insuperable obstacles' to the exercise of the Court's jurisdiction. . .." *Socialist Labor Party v. Gilligan*, 406 U.S. 583, 588 (1972) (citation omitted). Thus, in the past, even where jurisdiction technically existed, this Court has declined to exercise it "unless the case 'tenders the underlying constitutional issues in clean-cut and concrete form.'" *Id.* (citation omitted).

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2 In *Thornburgh*, which held that mandatory jurisdiction exists only to review final judgments, this Court exercised its certiorari jurisdiction to review the preliminary injunction imposed by the Court of Appeals after the trial court had denied injunctive relief. *Thornburgh*, 476 U.S. at 755. There, the District Court had analyzed a facial challenge to an abortion statute based on a stipulated record. *Id.* By way of contrast, the District Court here made preliminary findings on a contested factual record in an as-applied challenge.

II. NO ISSUES OF EXCEPTIONAL IMPORTANCE ARE PRESENTED FOR REVIEW.

A. The Court Of Appeals' Decision Replicates Recent Decisions Of This Court And Is In Accord With Decisions Of Other Courts of Appeals That Have Enjoined Regulatory Schemes That Burden The Abortion Right.

The case at bar is not of exceptional importance meriting review because the decision below merely replicates this Court's decisions in *City of Akron v. Akron Center For Reproductive Health, Inc.*, 462 U.S. 416 (1983), and *Thornburgh*, 476 U.S. 747. Contrary to the inference left by defendants (Juris St. 24), this Court did not uphold a comprehensive licensing and regulatory scheme in *Akron*. Instead, in *Akron*, and again in *Thornburgh*, this Court held that health and safety regulations that burden the abortion right without medical justification are unconstitutional. *See Akron*, 462 U.S. 416 (health regulations restricting second trimester abortions to hospital are unconstitutional); *Thornburgh*, 476 U.S. at 763, 765-66 (counseling regulations which limit physician's professional discretion are unconstitutional, as are abortion-specific reporting requirements).

Other courts of appeals, in cases defendants do not cite, have displayed little difficulty in applying this Court's precedents to enjoin similar state attempts to burden providers of first and early second trimester abortions through purported health and safety regulations. Indeed,

most courts that have examined comprehensive regulatory schemes, either specifically directed at abortion services in the early stages of pregnancy or general in nature but having an impact on the abortion right, have found that such regulations unconstitutionally interfere with a woman's fundamental right to make and effectuate the decision to terminate a pregnancy. *See, e.g., Birth Control Centers, Inc. v. Reizen*, 743 F.2d 352, 364-65 (6th Cir. 1984) (staffing, structural and equipment requirements, similar to those challenged here, declared unconstitutional because compliance would be difficult and would increase the cost of each individual abortion); *Mahoning Women's Center v. Hunter* , 610 F.2d 456, 458-60 (6th Cir. 1979), *vacated on other grounds*, 447 U.S. 918 (1980) (mem.) (city ordinance that required first trimester abortions to be performed in clinics nearly identical to hospital surgical wards found unconstitutional); *Friendship Medical Center, Ltd. v. Chicago Bd. of Health*, 505 F.2d 1141, 1144-45 (7th Cir. 1974), *cert. denied*, 420 U.S. 997 (1975) (regulatory scheme imposed upon first trimester abortion providers, remarkably similar to the tripartite scheme the State defends here, found unconstitutional). *See also Fox Valley Reproductive Health Care Center, Inc. v. Arft*, 446 F. Supp. 1072, 1074-75 (E.D. Wis. 1978) (general clinic licensing provisions preliminarily enjoined as applied to first trimester abortion provider because of "burdensome interference"); *Indiana Hospital Licensing Council v. Women's Pavilion*, 420 N.E.2d 1301 (Ind. App. 1981)

(licensing scheme found impermissibly to burden right to first trimester abortion).[3]

Defendants overlook this unequivocal support for the Court of Appeals' decision and rely instead on cases that have been superseded by more recent authoritative decisions. Defendants' reliance on *Abortion Coalition of Michigan, Inc. v. Michigan Dep't of Public Health*, 426 F. Supp. 471 (E.D. Mich. 1977) (Juris. St. 26), is particularly inappropriate because the regulations at issue were struck down later in *Reizen*, 743 F.2d 352, a post-*Akron* decision.[4] *Hodgson v. Lawson*, 542 F.2d 1350 (8th Cir. 1976) (*per curiam*) (Juris. St. 25), is similarly inapposite. In *Hodgson*, the court stated its approval of a requirement, clearly invalid after this Court's 1983 decision in *Akron*, that all second trimester abortions be performed in hospitals. 542 F.2d at 1354. Moreover, on remand for an evidentiary hearing, the three-judge District Court held unconstitutional the regulations, like those at issue here, found to impose significant and unjustified burdens on the fundamental right

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3 *Simopoulos v. Virginia*, 462 U.S. 506 (1983), is not to the contrary. In *Simopoulos*, this Court upheld only state regulation of a late second trimester abortion performed at 22 weeks of pregnancy. 462 U.S. at 508, 510 n.2. At this advanced stage of pregnancy, a state's interest in the health of the woman becomes compelling. *Roe v. Wade*, 410 U.S. 113, 163 (1973); *see also* App. 19 n.8.

4 *See Reizen*, 508 F. Supp. 1366, 1369 n.1 (E.D. Mich. 1981), *aff'd in part, rev'd in part*, 743 F.2d 352 (6th Cir. 1984) (stating that the challenged provisions are identical to those in *Abortion Coalition*); *see also Ragsdale v. Turnock*, 625 F. Supp. 1212, 1229 n.22 (1985); App. 144-45 (same).

of a woman to choose to have an abortion. *Hodgson v. Lawson*, No. 4-74-155 (D. Minn., March 7, 1977).[5]

B. The Court Of Appeals Correctly Applied Legal Standards Established By This Court For Review Of Provisions Affecting The Fundamental Right Of Abortion During The Early Stages Of Pregnancy.

State regulation of abortion during the first and early second trimesters of pregnancy is constitutionally permissible only if: 1) such regulation does not in any way burden the abortion decision or its effectuation, *see Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976); or 2) the regulation is integral to the procedure, as contemplated by the *Roe* decision. *See Connecticut v. Menillo*, 423 U.S. 9 (1975) (*per curiam*) (Court upheld statute requiring that abortions be performed by licensed

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5 *Westchester Women's Health Organization v. Whalen*, 475 F. Supp. 734 (S.D.N.Y. 1979), also cited by defendants (Juris. St. 26), is of doubtful validity, having approved a second trimester hospitalization requirement. The *Westchester* court, unlike this Court in *Akron*, failed to consider an increase in cost as an unconstitutional burden to the effectuation of the abortion decision. The First Circuit's decision in *Baird v. Department of Public Health*, 599 F.2d 1098 (1st Cir. 1979), upon which defendants also rely (Juris. St. 25), suffers from the same flaw as the Eighth Circuit's decision in *Hodgson*. That case, which upheld a regulatory scheme, was decided on a stipulated record with no evidence of the impact on a fundamental right or of the safety of the abortion procedure as compared to other surgical procedures. *Compare* App. 21.

physicians because *Roe* contemplated that physician would be integral part of abortion process). Thus, during the early stages of pregnancy, a "woman must be permitted, in consultation with her physician, to decide to have an abortion and to effectuate that decision 'free of interference by the State.'" *Akron* 462 U.S. at 429-30, (quoting *Roe*, 410 U.S. at 163).

Where, as here, the evidence demonstrates that a regulatory scheme significantly burdens first and early second trimester abortions, the State must show, by strict factual proof, that such regulation is necessary to the safe performance of the abortion procedure. *See Thornburgh*, 476 U.S. at 759.[6] As this Court repeatedly has warned, "[t]he States are not free, under the guise of protecting maternal health," to create obstacles that burden a woman's effectuation of her decision to have an abortion. *Id.* at 759. The Court of Appeals' decision adheres to this well-settled principle, which defendants show no reason to disturb.

As discussed above, the abortion-directed regulatory scheme here significantly burdens the ability of a woman to effectuate her choice to have an abortion. In addition, defendants failed to offer any justification to support the burdensome scheme.

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6 Medical technology now has made early second trimester abortions, as well as first trimester abortions, extremely safe. *Akron*, 462 U.S. at 429 n.11, *see also* App. 16, 20 n.8. Thus, the Court has struck down purported health regulations burdening early second trimester procedures in the same manner as it has struck regulations burdening first trimester procedures. This Court has recognized that States may have a compelling interest in applying narrowly tailored regulations only in the later stages of pregnancy. *Akron*, 462 U.S. at 427.

Each of the three physicians who testified as an expert witness at trial, including the defendants' expert, testified emphatically that first and early second trimester abortions are among the safest of outpatient procedures. Contrary to the defendants' implications (Juris. St. 8-9), these physicians testified that the State had no legitimate medical reason to single out abortion providers for the imposition of an additional layer of regulation. (Barton, Dep. 95-96, 174, Tr. 466, 475; Ragsdale, Tr. 66-68, 80; Hern, Tr. 238-42, 274, 279.) *See also* App. 30.[7]

The factual findings further demonstrate that the regulatory provisions imposed under the ASTC Act, particularly the costly physical plant requirements, "do not have 'any medical justification.'" App. 29 (citations to the record omitted). Indeed some of the provisions were shown to be "medically poor." App. 29. Thus, as the courts below found, this scheme imposes requirements that force first trimester abortion providers to incur the great costs of building "small hospitals," yet fails to further the safety of the procedure. App. 29.

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7 Nonetheless, defendants continue to defend the statutory scheme, especially the ASTC Act, with its abortion-specific subparts, as medically necessary. Among the provisions lauded by defendants (Juris. St. 12) is a counseling requirement nearly identical to that struck in *Thornburgh*. The ASTC regulations demand that each woman, even if faced with a life-threatening pregnancy, be advised of the alternatives to abortion, although that information might well, as found by the Court of Appeals, "'be cruel as well as destructive of the physician-patient relationship.'" App. 27-28, (quoting *Thornburgh*, 476 U.S. at 763).

Defendants' presentation of this complex regulatory scheme obscures all but its most innocent provisions. (Juris. St. 11-14.) Defendants disregard all of the essential requirements for licensing that impose significant burdens. *See* Ambulatory Surgical Treatment Center Licensing Requirements, 77 Ill. Adm. Code, Chapter 1, Subchapter b, Part 205. For example, a facility must have, among other things: (a) a procedure room that is the same size as that recommended for a tertiary care hospital, Section 205.1360(b); App. 232; (b) a "control station" located to allow visual surveillance of traffic entering the operating suite, Section 205.1370(a); App. 233; and (c) an elaborate air-conditioning, heating and ventilation system to provide specified filter efficiencies and airflow relationships between rooms that would be found in a sophisticated operating room suite in a complete care hospital. Section 205.1540; App. 242-43; *see also* App. 5. By the admission of the State's own witnesses, these and other burdensome requirements were designed to accommodate major surgical procedures, not minor procedures such as early abortions. (Linder, Dep. 48; Ramsay, Tr. 764.)

Although a few regulations are, as defendants suggest, consistent with medical standards for abortion providers, the cumulative effect of the ASTC Act, which defendants ignore, is to regulate every minute facet of a first or early second trimester procedure. App 23-25. As a result, physicians are locked into a statutory "straitjacket," *see Danforth*, 428 U.S. 52, 67 n.8, which denies them the professional flexibility needed to make the "best medical

judgment" for each individual woman. App. 27.[8] Further, the cost of compliance with these onerous requirements was found to be prohibitive to potential abortion providers, as well as to women seeking early abortions. App. 22-23.[9]

Defendants' assertion of a general regulatory objective that "'all medical procedures, including abortions, [be] performed under conditions that insure maximum safety'" (Juris. St. 24-25 [citation omitted]) will not support this burdensome regulatory scheme. As the Court of Appeals found, the ASTC Act "was enacted primarily with abortion

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8 The American College of Obstetricians & Gynecologists' Standards for Obstetric-Gynecological Services, Sixth Edition, explicitly approves the performance of first and early second trimester abortions in a physician's office, the specifications of which are left to the doctor's professional discretion. (ACOG Standards 60, 64 [6th Ed. 1985].) Defendants seriously misconstrue these standards with their claim that ACOG recommends uniformly applying the hospital-like standards established in the ASTC Act to first and early second trimester abortion procedures. (Juris. St. 12.)

9 Defendants' contention that "reasonable compliance" with the regulatory scheme would increase the cost of each abortion by only a moderate amount (Juris. St. 27) disregards the District Court's factual finding, affirmed by the Court of Appeals, that compliance would increase the cost per procedure by almost 100 percent more than defendants' claimed amount. *Id.* Defendants do not define "reasonable compliance" nor does the statute specify a consistent standard of required compliance. Indeed, the evidence introduced at trial shows that defendants demand inconsistent levels of compliance. For example, prior to termination of Dr. Ragsdale's lease, his facility had been licensed as "'substantially complying;'" however, "officials charged with enforcing the regulations told Dr. Ragsdale that they would require 'considerably more substantial compliance'" when he moved to a new facility. App 9-10.

clinics in mind. . .." App. 21. In *Thornburgh*, the Court sent a strong message to states, such as Illinois, with a history of anti-abortion legislation, that it will not tolerate government interference with a woman's decision to have an abortion, or her physician's medical discretion in effectuating that decision, under the guise of regulating general health and welfare. *Thornburgh*, 477 U.S. at 759.

Further, defendants' own contention that they no longer apply these purported health regulations to all who provide early abortion services (*see* Juris. St. 9) undercuts their claimed concern for safety. As the Court of Appeals noted, "[t]he State's attempt to regulate experienced, and therefore safer, physicians, more heavily than the occasional abortion provider thus appears . . . to lack even a reasonable basis." App. 24.[10]

In light of the lower courts' findings that the challenged scheme was directed at abortions, defendants cannot obtain review by arguing that the challenged scheme is "abortion-neutral" and therefore subject only to a rational basis standard of review. (Juris. St. 25.) Moreover, defendants' proposed rational basis analysis, which they claim is "supported by decisions of this Court in other contexts" (Juris. St. 26), has been expressly rejected by the Court in the abortion context. State regulations, whether

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10 Likewise, the attempt to justify the CON portion of the scheme as a cost-containment measure (Juris. St. 6) cannot provide a compelling interest because "the State has discontinued use of [the CON] method, [and] the State has never made such payments for abortions." App. 31. Further, "[w]here the exercise of constitutional rights is concerned, the government may play no role in determining whether outlets for their exercise are 'needed.'" App. 31.

abortion-neutral or abortion-specific, found to impose restrictions on first and early second trimester procedures must be strictly reviewed and enjoined unless justified by a compelling governmental interest. *Akron*, 462 U.S. at 420-21 n.1. Accordingly, in *Akron*, this Court expressly declined the City of Akron's invitation to apply the rational basis analysis to abortion regulations.[11]

Given the substantial burdens resulting from the scheme, and the absence of any compelling justification, the Court of Appeals appropriately affirmed the preliminary injunction ordered by the District Court. Not only is a rational basis standard "wholly incompatible with the existence of the fundamental right recognized in *Roe v. Wade*," *Akron*, 462 U.S. 420-21 n.1, but the Court of Appeals indicated that this burdensome scheme lacked even a reasonable basis. App. 24.

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11 The Supreme Court cases defendants cite (Juris. St. 26) do not support their argument that a rational basis standard is appropriate. In none of those cases did the Court apply a rational basis standard. Indeed, in *Minneapolis Star & Tribune Co. v. Minn. Comm'r of Revenue*, 460 U.S. 575 (1983), this Court strictly scrutinized a special tax on newspapers, even though there was no evidence of legislative intent to restrict newspapers. Nonetheless, the Court struck down the tax which, like the challenged scheme here, was found to impose a financial burden on the exercise of a fundamental right and which did not serve any compelling governmental interest.

None of defendants' cases refutes the well-established principle that when a general regulatory provision is applied in a manner that burdens a fundamental right, it is unconstitutional. *Compare Wisconsin v. Yoder*, 406 U.S. at 220 (neutral compulsory education law applied to members of Amish religion unconstitutionally burdened their right to the free exercise of religion).

C. The Decision Below Is Consistent With This Court's Decisions In The Areas Of Justiciable Controversies And Severability.

1. In Light Of Defendants' Continuing Policy Of Enforcement, The Court Of Appeals Appropriately Affirmed The Preliminary Injunction.

Defendants' claim that the ruling below conflicts with Supreme Court decisions concerning justiciable controversies (Juris. St. 21-23) does not present an issue within the ambit of 28 U.S.C. § 1254(2); the Court of Appeals' ruling that the case was not moot does not constitute a declaration that a state statute is invalid "as repugnant to the Constitution, treaties or laws of the United States. . .." 28 U.S.C. § 1254(2). Further, defendants present no conflict that would warrant the exercise of certiorari jurisdiction.

Without an injunction, Dr. Ragsdale would have been forced to close his practice, and plaintiff Margaret Moe would not have been able to offer abortion services to her patients. App. at 22. Defendants' employees are given "absolute prosecutorial discretion" as to when and how to enforce statutory provisions (Juris. St. 10). Testimony by defendants' own enforcement personnel revealed that defendants have no consistent policy as to nonenforcement, nor have they publicized in any consistent fashion their alleged nonenforcement policy. App. 10, 14.

In light of the threat of continued enforcement, the Court of Appeals properly rejected defendants' claim that their alleged nonenforcement somehow rendered the controversy moot or nonjusticiable. App. 13-14. Regardless of the label (Juris. St. 21-23), this Court has made clear, in cases relied upon by the Court of Appeals, App. 11, but disregarded by defendants, that voluntary cessation of illegal conduct does not deprive a lower federal court of jurisdiction to affirm a preliminary injunction unless the wrongful conduct could not reasonably be expected to recur, *City of Mesquite v. Aladdin's Castle, Inc.*, 455 U.S. 283, 289 n.10 (1982), and all harm caused by the illegal conduct has been "'irrevocably eradicated.'" *City of Los Angeles v. Lyons*, 461 U.S. 95, 101 (1983) (citation omitted). Defendants could not meet this standard here. Particularly considering Illinois' history of enacting restrictive abortion legislation and reenacting such legislation after it previously has been stricken, *see Charles v. Daley*, 749 F.2d 452, 458 (7th Cir. 1984), *appeal dism'd sub nom., Diamond v. Charles*, 476 U.S. 54 (1986), physicians "should not have to risk loss of their professional licenses to explore the contours of the asserted non-enforcement position." App. 14. *Contrast Poe v. Ullman*, 367 U.S. 497 (1961) (cited at Juris. St. 23) (no justiciable controversy because statute essentially not enforced in 82 years).[12]

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12 Defendants inappropriately rely on *J.N.S. v. State of Indiana*, 712 F.2d 303 (7th Cir. 1983), and *C.I.O. v. McAdory*, 325 U.S. 472 (1945), to argue that no justiciable controversy existed before the Court of Appeals. In those cases, a constitutional violation would have occurred only had the challenged statutes been given a particular construction, and the courts in both cases found no threat of such a construction. *See also Alabama State Federation of Labor v. McAdory*, 325 U.S. 450 (1945), *relied on in C.I.O.*, 325 U.S. 472. By contrast,

(Footnote continued on the following page)

Defendants' alternative argument, that the Eleventh Amendment barred the entry of portions of the preliminary injunction, mischaracterizes this Court's decision in *Green v. Mansour*, 474 U.S. 64 (1985), and the Court of Appeals' decision in *Watkins v. Blinzinger*, 789 F.2d 474 (7th Cir. 1986), *cert. denied*, ___ U.S. ___, 107 S. Ct. 1976 (1987). In those cases, the Eleventh Amendment was a barrier to further federal litigation because a ruling by the federal court effectively would have resulted in financial consequences for the State because of past violations of federal law. No such risks exists here, where plaintiffs have not sought damages or economic relief from the State. Further, when the purpose of the federal court remedy is to require the state officer to conform future conduct to the dictates of federal law, it has long been established that the Eleventh Amendment erects no barrier to suit. *Ex Parte Young*, 209 U.S. 123 (1908).

2. The Court Of Appeals Properly Enjoined The Entire Regulatory Scheme As It Applies To Early Abortion Services.

Cognizant of the policies underlying the severability doctrine, both the District Court and the Court of Appeals tailored the injunction to apply only to the extent required to protect plaintiffs' constitutional rights, thereby leaving the State free to apply the regulatory scheme to all non-abortion

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(Continued)
in the present case, the State defends unconstitutional laws by claiming they will not enforce the express terms of the statutes as they were enacted by the Legislature.

procedures. *Compare Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984). This narrow injunction, limiting application of the law as opposed to striking it entirely, is consistent with the Illinois General Assembly's expressed intention in the ASTC Act. *See* Ill. Rev. Stat. ch. 111 1/2, § 157-8.15; App. 165 (to the extent that the Act is held unconstitutional as applied to particular person(s), court appropriately can sever by allowing the statute to remain enforceable as to all others).

The Court of Appeals correctly refused defendants' invitation to rewrite the challenged legislation. App. 32-33. It held that the licensing provision, "'an integral part' of the scheme as a whole," was itself unconstitutional as it applied to plaintiffs. App. 32, *see also* App. 23-24. Without the licensing requirement, the remaining provisions, many of which themselves were unconstitutionally burdensome, would not be applicable. Thus, the Court of Appeals held that it could not "'untangle the constitutional from the unconstitutional provisions . . .,'" App. 33 (quoting *Mahoning*, 610 F.2d at 460), without impermissibly usurping the Illinois General Assembly's legislative function. App. 33.

This is consistent with defendants' own cases. Severing specific provisions is not appropriate "'if what is left is [not] fully operative as a law,'" or if "'it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not.'" *Buckley v. Valeo*, 424 U.S. 1, 108-09 (1976) (*per curiam*) (quoting *Champlin Refining Co. v. Corporation Commission*, 286 U.S. 210, 234 [1932]); *see also* Juris. St. 29. Here, neither condition is met.

CONCLUSION

For all of the foregoing reasons, this appeal should be dismissed, or in the alternative, the judgment below should be affirmed.

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REPLY

BRIEF

(4)

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No. 88-790

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, et al.,

Appellants,

v.

RICHARD M. RAGSDALE, M.D., et al.,

Appellees.

On Appeal From The United States Court Of Appeals For The Seventh Circuit

APPELLANTS' REPLY TO MOTION TO DISMISS OR AFFIRM

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TABLE OF CONTENTS

	Page
TABLE OF CONTENTS	i
TABLE OF AUTHORITIES	ii
THIS COURT HAS APPELLATE JURISDICTION TO REVIEW THE JUDGMENT OF THE COURT OF APPEALS PURSUANT TO 28 U.S.C. SECTION 1254(2)	1
THE QUESTIONS PRESENTED ARE SUBSTANTIAL	4
A. THE COURT OF APPEALS ERRONEOUSLY FOUND THAT THE CHALLENGED STATUTES AND REGULATIONS ARE UNCONSTITUTIONAL	4
B. THE MAJORITY OPINION CONFLICTS WITH DECISIONS OF THIS AND OTHER COURTS REGARDING SEVERANCE OF PURPORTEDLY UNCONSTITUTIONAL PROVISIONS	8
C. THE COURT OF APPEALS ERRONEOUSLY ASSUMED JURISDICTION OVER UNENFORCED PROVISIONS	9
CONCLUSION	10

TABLE OF AUTHORITIES

Cases	Page(s)
Baird v. Department of Public Health, 599 F.2d 1098 (1st Cir. 1979)	6
Birth Control Centers, Inc. v. Reizen, 743 F.2d 352 (6th Cir. 1984)	5, 7, 8
City of Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416 (1983)	5, 6
Ex Parte Young, 209 U.S. 123 (1908)	10
Fox Valley Reproductive Health Care Center, Inc. v. Arft, 446 F.Supp. 1072 (E.D. Wis. 1978)	6
Friendship Medical Center, Ltd. v. Chicago Board of Health, 505 F.2d 1141 (7th Cir. 1974), *cert. denied*, 420 U.S. 997 (1975)	6
Hodgson v. Lawson, 542 F.2d 1350 (8th Cir. 1976)	6
Mahoning Women's Center v. Hunter, 610 F.2d 456 (6th Cir. 1979), *vacated on other grounds, mem.*, 447 U.S. 918 (1980)	5
Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747 (1986)	3, 5

Constitutional Provisions

U.S. Const. Amend. XI	9, 10

Statutes

28 U.S.C. Section 1254(2)	1, 2, 3, 4
Ambulatory Surgical Treatment Center Act, Ill. Rev. Stat. ch. 111½, pars. 157-8.1 *et seq.*	*passim*
Health Facilities Planning Act, Ill. Rev. Stat. ch. 111½, pars. 1151 *et seq.*	*passim*
Medical Practice Act, Ill. Rev. Stat. ch. 111, par. 4400-22	*passim*

Regulations

Ambulatory Surgical Treatment Center Licensing Requirements, 77 Ill. Adm. Code, Ch. 1, Section 205, Subchapter 6	*passim*

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THIS COURT HAS APPELLATE JURISDICTION TO REVIEW THE JUDGMENT OF THE COURT OF APPEALS PURSUANT TO 28 U.S.C. SECTION 1254(2)

In their Jurisdictional Statement (pp. 1-2), defendants demonstrated that this Court has appellate jurisdiction to review the final judgment entered by the Court of Appeals. That judgment held unconstitutional the challenged

provisions of the Illinois Medical Practice Act (MPA), the Illinois Ambulatory Surgical Treatment Center Act (ASTC) and related regulations, and the Illinois Health Facilities Planning Act (HFPA) to the extent any person or facility offers or performs, or desires to offer or perform first and early second trimester abortions or abortion-related gynecological procedures.

The plaintiffs attempt to argue that this matter is not subject to review under 28 U.S.C. Section 1254(2). In so arguing, the plaintiffs incorrectly focus upon the district court preliminary injunction order, rather than the decision of the Court of Appeals. (Pls.' Motion, pp. 5-7). In addition to affirming the preliminary injunction, the Court of Appeals invalidated the licensure requirement and struck the other challenged provisions as applied to first and early second trimester abortions.

In discussing the severability issues presented by the case, moreover, the plaintiffs acknowledge that the Court of Appeals has held that the Illinois general "licensing provision . . . was itself unconstitutional as it applied to plaintiffs." (Pls.' Motion, p. 21; App. 25). Similarly, the Court of Appeals need not have considered the severability issues unless the statutes and regulations had been held unconstitutional. In light of the holding by the Court of Appeals, this Court has appellate jurisdiction under 28 U.S.C. Section 1254(2).

In addition, the plaintiffs misstate that they and the district court contemplated further evidentiary hearings after the preliminary injunction trial. (Pls.' Motion, p. 6). That statement is contradicted by the comments of plaintiffs' counsel and the district court judge subsequent to the issuance of the preliminary injunction decision. At that time, plaintiffs' counsel volunteered the following statements:

> MR. GILBERT: One other matter, and this doesn't relate directly to this order, and that is, just in terms of the future course of this proceeding, given the scope of the evidentiary hearing and the briefing that has gone on and the scope of your Honor's order, it seems to us that there probably isn't a need to have another trial in this matter and that we have pretty much aired the issues here and relatively completely and, to that end, we have made a suggestion to the state, a request, that we would be willing to turn this into a final injunction order pursuant to Rule 65, which allows a proceeding for preliminary injunction to be a proceeding for a final and permanent injunction as well. (Tr. 861-62).

In the same vein, the district court judge and plaintiffs' counsel stated as follows:

> THE COURT: . . . I can't really think of anything more that either side would put in that would really make all that much difference in the Seventh Circuit's decision in the case. It is really—the guts of the argument on both sides are in and the evidence is in. It is really a question of interpreting the Supreme Court decisions and maybe drawing a few reasonable inferences. But there really isn't all that much in the way of factual disputes, it is really more a question of interpretation of the existing laws. (Tr. 864-65).
>
> MR. GILBERT: Yes. Right. That's how we see it. . . . (Tr. 865).

In *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986), this Court concluded that it had no appellate jurisdiction under Section 1254(2). 476 U.S. at 755. This Court reached that conclusion because the Third Circuit had not held the entire Act unconstitutional, had invalidated only some provisions, and had remanded the case for further development of the facts. 476 U.S. at 754-55.

In this case, however, the Seventh Circuit did hold the challenged acts unconstitutional, thereby invalidating all of the regulatory provisions as applied to first and early second trimester abortions. The Seventh Circuit did not remand for further development of the facts. Clearly, the Seventh Circuit judgment is final and this Court has appellate jurisdiction under 28 U.S.C. Section 1254(2).

THE QUESTIONS PRESENTED ARE SUBSTANTIAL

A.

THE COURT OF APPEALS ERRONEOUSLY FOUND THAT THE CHALLENGED STATUTES AND REGULATIONS ARE UNCONSTITUTIONAL.

In enacting the ASTC Act, Illinois recognized the increasing trend toward the development of free-standing or outpatient surgical facilities. Abortions are performed in 22 of the 42 outpatient surgical facilities which are licensed in Illinois. The decision of the Court of Appeals has exempted those 22 surgical facilities from licensure and regulation to the extent they perform first and early second trimester abortions.

This exemption has undermined Illinois' duty and authority to protect patients who are undergoing abortions at such facilities in the same manner that the state can protect patients who are undergoing other surgical procedures. This exemption is inconsistent with decisions of other circuits and, contrary to the plaintiffs' suggestions, is not supported by decisions of this Court.

The plaintiffs suggest that this case is unimportant and attempt to argue that the decision of the Court of Appeals "replicates" this Court's decisions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983) and *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986). (Pls.' Motion, p. 8). That argument is incorrect.

At issue in this case is the State's authority to license and regulate outpatient surgical facilities in which abortions are performed to the same extent it licenses and regulates outpatient surgical facilities in which other surgical procedures are performed. Neither *Akron* nor *Thornburgh* involved such generally applicable statutes and regulations. Both of those cases addressed challenges to abortion-specific statutes.

In fact, none of the cases relied upon by the plaintiffs support the Court of Appeals' decision to exempt outpatient surgical facilities in which abortions are performed from a general licensure provision. For example, plaintiffs cite *Birth Control Centers, Inc. v. Reizen*, 743 F.2d 352 (6th Cir. 1984). In that case, however, the Sixth Circuit did not invalidate on privacy grounds the State's authority to license outpatient surgical facilities in which abortions are performed. In fact, the licensure question was not perceived to involve privacy rights and was dealt with as an equal protection issue. More importantly, the court upheld the requirement as reasonable. 743 F.2d at 358-59.

Plaintiffs also rely upon *Mahoning Women's Center v. Hunter*, 610 F.2d 456 (6th Cir. 1979), *vacated on other grounds, mem.*, 447 U.S. 918 (1980). In that case, the Sixth Circuit invalidated in its entirety an ordinance which singled out for extensive regulation only medical clinics

performing abortions. Similarly, plaintiffs cite the decisions in *Friendship Medical Center, Ltd. v. Chicago Board of Health*, 505 F.2d 1141 (7th Cir. 1974), *cert. denied*, 420 U.S. 997 (1975) and *Fox Valley Reproductive Health Care Center, Inc. v. Arft*, 446 F.Supp. 1072 (E.D. Wis. 1978). Again, these cases dealt with abortion-specific ordinances, rather than generally applicable licensure provisions. Thus, these cases do not support the decision of the Seventh Circuit to exempt from general licensure provisions outpatient surgical facilities in which first and early second trimester abortions are performed.

Contrary to plaintiffs' assertion, *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 420 n.1 does not hold that abortion-neutral statutes and regulations "must be strictly reviewed and enjoined unless justified by a compelling government interest." (Pls.' Motion, pp. 16-17). *Akron* involved a challenge to an ordinance enacted "to regulate the performance of abortions" (*id.* at 419), rather than abortion-neutral provisions. Defendants maintain that the rational basis test should have been applied to the abortion-neutral provisions at issue in this case. (Juris. St., pp. 25-26).

Plaintiffs' attempts to distinguish *Baird v. Department of Public Health*, 599 F.2d 1098 (1st Cir. 1979) and *Hodgson v. Lawson*, 542 F.2d 1350 (8th Cir. 1976) also miss the mark. Those cases uphold licensing standards of outpatient surgical facilities in which pregnancy terminations are performed. Thus, those decisions conflict with the ruling of the Seventh Circuit in this case which held that licensing of such facilities constitutes an unconstitutional invasion of privacy.

Plaintiffs state that defendants failed to offer any justification to support the challenged statutes and regulations. (Pls.' Motion, p. 12). That statement ignores the record

in this case. In the Jurisdictional Statement, defendants demonstrated the legitimate and substantial purposes of the challenged statutes (Juris. St., pp. 5-6 and 25) and regulations (Juris. St., pp. 11-14).

In addition, the plaintiffs suggest that it is not reasonable for the State to regulate surgical facilities in which abortions are performed more heavily than doctor's offices in which abortions are performed. (Pls.' Motion, p. 16). The Sixth Circuit dealt with a similar argument in *Birth Control Centers, Inc. v. Reizen*, 743 F.2d 352 (6th Cir. 1984). The court recognized that in private offices the physician generally has direct control over staff and office functions, while in outpatient surgical facilities nonphysicians may have control over personnel, equipment and the design of the facility. The Sixth Circuit concluded, therefore, that it was not unreasonable for Michigan to decide to regulate free-standing surgical facilities including abortion clinics while not regulating physicians' offices. 743 F.2d at 358-59. The statutes and regulations which were invalidated in this case reflect a similar reasonable decision by the State of Illinois.

The State has the duty and the power to protect the health, safety and welfare of its citizens by licensing and regulating outpatient surgical facilities. The State's important interests in assuring that certain minimal standards be complied with at such facilities do not cease to exist when abortions are performed at such facilities.[1] In

[1] The American College of Obstetricians and Gynecologists' Standards for Obstetric-Gynecologic Services, Sixth Edition [ACOG Standards] provides that "[A]mbulatory care facilities for abortion services should meet the same standards of care as for other surgical procedures." (ACOG Standards 62). The Standards further provide that "Ambulatory surgical facilities that are free-standing or hospital-based should maintain the same surgical, anesthetic, and personnel standards that hospitals do." (ACOG Standards 61).

fact, the plaintiffs' trial experts testified that medical education in this country has paid little attention to abortion services and that there are few surgical procedures given so little attention and so underrated in its potential hazard as abortion.

B.

THE MAJORITY OPINION CONFLICTS WITH DECISIONS OF THIS AND OTHER COURTS REGARDING SEVERANCE OF PURPORTEDLY UNCONSTITUTIONAL PROVISIONS.

In the Jurisdictional Statement, defendants demonstrated that the majority opinion of the Seventh Circuit erred in rejecting the argument that any purportedly unconstitutional provisions be severed. (Juris. St., pp. 28-29). Plaintiffs ignore the thrust of defendants' argument. (Pls.' Motion, pp. 20-21). In this case, the lower courts and plaintiffs argue that the appropriate analysis entails the estimation of the cost of compliance with all of the challenged regulations. (App. 22). This aggregated sum supposedly substantiates the "impact on the abortion decision." *Id.* The nature and degree of the alleged burden on constitutional rights should not depend upon the number or volume of statutes and regulations which are challenged. Rather, those statutes and regulations should be scrutinized independently and on their own merit.

Birth Control Center, Inc. v. Reizen, 743 F.2d 352 (6th Cir. 1984) offers further support for the defendants' argument that the Seventh Circuit improperly invalidated all of the challenged provisions. In *Reizen*, the Sixth Circuit upheld the licensure requirement, upheld certain regulations and struck other regulations. That court did not refuse to sever those provisions which it found unconstitutional. Rather, the challenged statutes and regulations

were individually analyzed. The same procedure should have been utilized by the Seventh Circuit in this case.

C.

THE COURT OF APPEALS ERRONEOUSLY ASSUMED JURISDICTION OVER UNENFORCED PROVISIONS.

In the Jurisdictional Statement, defendants demonstrated that the Seventh Circuit's assumption of jurisdiction over unenforced provisions conflicts with decisions of this Court and Courts of Appeals regarding justiciability standards as well as with decisions addressing the jurisdictional bar created by the Eleventh Amendment. (Juris. St., pp. 21-23). The plaintiffs, however, attempt to posit the case as one involving mootness issues. (Pls.' Motion, p. 19).

The uncontradicted evidence of record established that due to various court decisions, well prior to the commencement of this action, the State ceased to enforce certain challenged provisions: the abortion-specific language of par. 157-8.3 of the ASTC Act (App. 149-50); Sections 205.740 (App. 222) (prohibition of second trimester abortions in ASTCs) and 205.760 (App. 223) (abortion-specific reporting requirement) of the ASTC Regulations; and par. 4400-22 of the MPA. (App. 193).

While the plaintiffs now suggest that there is a "threat of continued enforcement" of those provisions, they do not specify what future conduct State officials must change to conform to the dictates of federal law. (Pls.' Motion, pp. 18-20). Even the Seventh Circuit noted that State officials cannot be required to remove or amend regulations which are not being enforced. (App. 13).

Defendants maintain that no justiciable controversy existed at the time of the filing of this case with respect to those challenged provisions which were no longer being

enforced. Further, the exception to the Eleventh Amendment's jurisdictional bar relied upon by the plaintiffs (Pls.' Motion, p. 20) is inapplicable to the challenge to the unenforced provisions. Absent some ongoing violation of federal law, *Ex Parte Young*, 209 U.S. 123 (1908) does not apply and the jurisdictional barrier created by the Eleventh Amendment remains intact.

CONCLUSION

For these reasons, this Court should deny plaintiffs' Motion to Dismiss or Affirm and should note probable jurisdiction of this appeal.

Respectfully submitted,

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January 27, 1989

JOINT

APPENDIX

Supreme Court, U.S.
FILED
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No. 88-790

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, et al.,

Appellants,

v.

RICHARD M. RAGSDALE, M.D., et al.,

Appellees.

On Appeal From The United States Court Of Appeals For The Seventh Circuit

JOINT APPENDIX

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TABLE OF CONTENTS

	PAGE
Notation Referencing Location of Reprints of Decisions, Judgments and Orders	iii
Chronological List of Relevant Docket Entries ..	1
Plaintiffs' Verified Complaint, filed June 28, 1985 .	3
Defendants' Answer, filed August 30, 1985	26
Plaintiffs' Exhibit No. 16	33
Plaintiffs' Exhibit No. 17, Handwritten Cost Estimate	35
Plaintiffs' Exhibit No. 18, Handwritten Cost Estimate	35
Plaintiffs' Exhibit No. 22	36
Plaintiffs' Exhibit No. 24	41
Defendants' Exhibit No. 2	48
Defendants' Exhibit No. 6	49
Plaintiffs' Opening Statement by Ms. Connell	64
Excerpts from Trial Transcripts	65
Post-Trial Proceedings	68
Trial Testimony of Richard M. Ragsdale, M.D.—	
Direct Examination	72
Cross-Examination	155
Redirect Examination	160
Trial Testimony of John J. Barton, M.D.—	
Direct Examination	165
Cross-Examination	170

Trial Testimony of Warren M. Hern, M.D.—
Direct Examination 180
Cross-Examination 213
Redirect Examination 222

Trial Testimony of Albert Tremari—
Direct Examination 226
Cross-Examination 229

Trial Testimony of Mary Jane Ramsay, R.N.—
Direct Examination 236
Cross-Examination 236

Trial Testimony of Mary Lloyd Lowe—
Direct Examination 241
Cross-Examination 244

Trial Testimony of Margaret Moe, R.N.—
Direct Examination 252
Cross-Examination 270

Trial Testimony of Michael V. Accettura—
Direct Examination 272
Cross-Examination 274

Excerpts from Oral Depositions:
Deposition of John J. Barton, M.D.—
Defendants' Exhibit No. 7
Direct Examination 280

Deposition of James A. Linder—
Plaintiffs' Exhibit No. 26
Defendants' Exhibit No. 9
Direct Examination 296

Deposition of Mary Jane Ramsay, R.N.—
Defendants' Exhibit No. 8
Direct Examination 306

Deposition of William Dilts—
Plaintiffs' Exhibit No. 25
Direct Examination 316
Cross-Examination 323

The following Opinions, Decisions, Judgments, and Orders have been omitted in printing this Joint Appendix because they appear on the following pages in the Appendix to the printed Jurisdictional Statement:

Memorandum Opinion and Order of the United States District Court for the Northern District of Illinois, Eastern Division, November 27, 1985 ..... A112

Class Certification and Preliminary Injunction Order of the United States District Court for the Northern District of Illinois, Eastern Division, December 11, 1985 ..... A109

Slip Opinion of the United States Court of Appeals for the Seventh Circuit, March 10, 1988 ..... A1

Judgment of the United States Court of Appeals for the Seventh Circuit, March 10, 1988 ..... A102

Order of the United States Court of Appeals for the Seventh Circuit Amending the Slip Opinion, April 13, 1988 ..... A103

Order of the United States Court of Appeals for the Seventh Circuit Denying the Petition for Rehearing and Suggestion for Rehearing *En Banc*, August 12, 1988 ..... A107

Amended Order of the United States Court of Appeals for the Seventh Circuit Denying the Petition for Rehearing and Suggestion for Rehearing *En Banc*, August 16, 1988 .... A105

No. 88-790

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, et al.,

Appellants,

v.

RICHARD M. RAGSDALE, M.D., et al.,

Appellees.

On Appeal From The United States Court Of Appeals For The Seventh Circuit

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JOINT APPENDIX

CHRONOLOGICAL LIST OF RELEVANT DOCKET ENTRIES

June 28, 1985—

Plaintiffs' Verified Complaint filed in the United States District Court for the Northern District of Illinois, Eastern Division.

August 30, 1985—

Defendants' Answer filed.

September 20, 1985—

Plaintiff Ragsdale's Motion for Preliminary Injunction and to Set Hearing filed.

September 23, 1985—

Plaintiffs' Motion to Maintain Class Actions filed.

November 18, 1985—

Preliminary Injunction Hearing held.

November 19, 1985—

Preliminary Injunction Hearing held.

November 20, 1985—

Preliminary Injunction Hearing held.

November 21, 1985—

Preliminary Injunction Hearing held.

November 22, 1985—

Preliminary Injunction Hearing held.

December 2, 1985—

Entered Opinion and Order dated November 27, 1985 granting plaintiffs' Motion for Certification of two plaintiff classes and one defendant class and granting plaintiffs' Motion for Preliminary Injunction.

December 12, 1985—

Entered Class Certification and Injunction Order dated December 11, 1985.

December 27, 1985—

Defendants' Notice of Appeal filed.

March 10, 1988—

Opinion and Judgment of the Court of Appeals for the Seventh Circuit.

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

RICHARD M. RAGSDALE, M.D., individually and on behalf of all other physicians similarly situated; MARGARET MOE, individually and on behalf of female patients at her medical facility; NORTHERN ILLINOIS WOMEN'S CENTER, an Illinois corporation; SARAH ROE, and JANE DOE, individually and on behalf of all other women similarly situated,

Plaintiffs,

v.

BERNARD J. TURNOCK, Acting Director of Illinois Department of Public Health; NEIL F. HARTIGAN, Attorney General, State of Illinois; RICHARD M. DALEY, on behalf of all State's Attorneys in the State of Illinois; GARY L. CLAYTON, Director of the Illinois Department of Registration and Education,

Defendants.

No. 85 C 6011

Judge Nordberg

VERIFIED COMPLAINT
(Filed June 28, 1985)

I. NATURE OF THE CONTROVERSY

1. This is a civil rights class action brought pursuant to 42 U.S.C. §§ 1983 and 1988 and 28 U.S.C. §§ 2201 and 2202, seeking declarative and injunctive relief. Plaintiffs challenge the constitutionality of the Illinois statutory scheme that, in effect, requires that all abortions, including those performed during the first trimester of pregnan-

cy, be performed in a hospital or its functional equivalent. These statutes, (1) the Medical Practice Act ("MPA"), Ill. Rev. Stat. ch. 111 § 4433, (2) The Ambulatory Surgical Treatment Center Act of Illinois ("ASTC Act"), Ill. Rev. Stat. ch. 111½ § 157-8.1 to § 157-8.16, and regulations promulgated thereunder, and (3) The Health Facilities Planning Act ("HFP Act"), Ill. Rev. Stat. ch. 111½ § 1151 to § 1168, and regulations promulgated thereunder, restrict impermissibly the performance of first and second trimester abortions. Plaintiffs challenge these Acts and their regulations as violative of rights secured by the First, Fourth, Fifth, Ninth and Fourteenth Amendments to the United States Constitution.

2. The MPA requires physicians to perform all abortions in hospitals or ambulatory surgical treatment centers. The ASTC Act and the HFP Act, as applied, then single out for discriminatory treatment and regulation "any facility in which a medical or surgical procedure is used to terminate a pregnancy."

3. The ASTC Act and regulations promulgated thereunder by the Illinois Department of Public Health ("IDPH") mandate that any medical office performing an abortion meet detailed structural, mechanical and administrative requirements.

(a) As a result, the ASTC Act and its regulations substantially inhibit, and in some cases prevent, a woman from exercising her right to choose to have an abortion under medically safe and reasonably inexpensive conditions. A woman's right to choose to have an abortion and to effectuate that decision is grounded upon the constitutional right of privacy, which finds its roots in the First Amendment, the Fourth Amendment, the Ninth Amendment, the penumbras of the Bill of Rights, and in the concept of ordered liberty protected by the Fourteenth Amendment to the Constitution of the United States.

(b) The ASTC Act and its regulations also prevent physicians who wish to perform abortions from exercising their best medical judgment, prevent physicians from implementing a woman's decision to choose abortion, and mandate physicians' compliance with vague, irrational and arbitrary requirements which are medically unnecessary, which depart from accepted medical practice, which increase the cost of abortions and which limit the availability of abortions. These regulations are not narrowly drawn, further no compelling state interest, deny physicians the right to practice medicine in accordance with the highest professional standards and deny physicians who perform abortions of their right to equal protection under the law, as guaranteed by the Fourteenth Amendment to the Constitution. Further, these restrictions deny operators of medical facilities of their right to equal protection under the laws and their right to operate a facility free from vague, irrational, arbitrary and unreasonable regulation.

4. The HFP Act, which also is administered by the IDPH, is applied to require all facilities in which a medical or surgical procedure is used to terminate a pregnancy to follow still another set of burdensome and medically unnecessary administrative procedures. The HFP Act, as interpreted by the IDPH to include abortion facilities, burdens a woman's fundamental privacy right to choose to have an abortion by the imposition of vague, irrational and arbitrary requirements which are medically unnecessary, which increase the cost of abortions and which limit the availability of abortions. These regulations are not narrowly drawn and further no compelling state interest. The HFP impermissibly restricts the rights of licensed physicians to practice medicine free from vague, irrational, arbitrary and unreasonable regulation, all in violation of

rights guaranteed by the United States Constitution. Further, these restrictions deny operators of medical facilities of their right to equal protection under the laws and their right to operate a facility free from vague, irrational, arbitrary and unreasonable regulation.

II. JURISDICTION AND VENUE

5. This Court has jurisdiction of this action pursuant to 28 U.S.C. § 1343.

6. Venue is proper in the Northern District of Illinois pursuant to 28 U.S.C. § 1391.

III. THE PLAINTIFF PARTIES

A. PLAINTIFFS

7. Richard M. Ragsdale, M.D., received his medical degree in 1959 from the University of Wisconsin at Madison and is a registered and licensed physician in the state of Illinois, and has been so licensed since 1971. He is currently engaged in the practice of gynecology and is the Director of the Northern Illinois Women's Center, located in Rockford, Illinois. He is a Diplomate of the American Board of Obstetrics and Gynecology and is a Clinical Assistant Professor at the University of Illinois, Rockford College of Medicine.

8. The Northern Illinois Women's Center is an Illinois corporation which provides gynecological, family planning and abortion services to women in the Rockford, Illinois area.

9. Dr. Ragsdale in his ordinary and usual practice receives requests from pregnant patients for an abortion performed by qualified medical personnel under proper medical conditions.

10. Dr. Ragsdale is competently trained to perform safe medical abortions. He presently offers and performs abortions as part of his medical practice. He would like to continue to offer such medical services.

11. Margaret Moe is a registered nurse and the sole owner and executive director of a medical facility in Cook County, Illinois. Ms. Moe's medical facility offers complete family planning education and medical care, including the prescription of contraceptives, pre-natal care and delivery-assistance for pregnant women.

12. In her ordinary and usual course of practice, Ms. Moe receives approximately 20-25 requests for abortions per week in her Cook County clinic.

13. Ms. Moe employs licensed physicians, specializing in obstetrics and gynecology, who are competently trained to perform safe medical abortions and who are willing to perform abortions in Ms. Moe's medical facility. Ms. Moe would like to offer abortion services in her facility.

14. Ms. Moe brings this action on her own behalf as the operator of a medical facility adversely affected by the challenged statutes and on behalf of female patients at her medical facility who desire abortions.

15. Sarah Roe is a female citizen of the United States, of child-bearing age and a resident of Rockford, Illinois. She is the mother of two children. Ms. Roe had an abortion at the Northern Illinois Women's Center for which she was charged only a minimal fee because of her current indigent financial situation. She may need another abortion in the future.

16. Jane Doe is a female citizen of the United States and of child-bearing age. She is a resident of Rockford, married and the mother of several children. From other

doctors in the Rockford area, Ms. Doe learned that uterine fibroids associated with a recent pregnancy posed a serious risk to her health; she was told that it was unlikely she would be able to carry her pregnancy past five months. Despite the severe pain and emotional trauma associated with this health threat, Ms. Doe was refused abortion services by several doctors in Rockford. Finally she was referred to Dr. Ragsdale at the Northern Illinois Women's Center from whom Ms. Doe received an abortion. Future pregnancies might also pose a serious risk to her health and would need to be terminated prior to term.

B. CLASS ALLEGATIONS

17. Dr. Ragsdale and his patients bring this action individually and as a class action, pursuant to Rule 23(a) and (b)(2) of the Federal Rules of Civil Procedure. Dr. Ragsdale challenges these statutes on behalf of all duly licensed physicians presently performing or desiring to perform abortions in the state of Illinois and on behalf of their women patients desiring abortions. Jane Doe, Sarah Roe and Margaret Moe challenge this statutory scheme on behalf of all Illinois women desiring abortions.

(a) The defined plaintiff class of physicians who perform or desire to perform abortions is so numerous that it is impracticable to join all physicians performing or desiring to perform abortions. The number of women patients desiring abortions is too numerous to join. In 1982, the last year for which statistics are available, approximately 65,860 women in Illinois had abortions.

(b) There are questions of law common to both the physician class and the class of women patients, including: whether the imposition of medically unnecessary restrictions upon the abortion procedure, pursuant to the MPA,

the ASTC Act and the HFP Act, unconstitutionally burden a woman's right to decide to have an abortion and whether the MPA, the ASTC Act and the HFP Act unconstitutionally impede plaintiff-physicians in their right to practice their profession.

(c) The claims of the named plaintiffs are typical of the claims of the class: plaintiff-physician practices medicine in the state of Illinois and performs abortions. Plaintiff-physician is governed by the restrictions imposed by the challenged statutes and the accompanying regulations. Plaintiff-patients' right to choose to have an abortion is impeded by the imposition of these medically unnecessary and costly restrictions.

(d) The named plaintiffs will fairly and adequately represent the interests of both the physician class and the patient class: they have no interests antagonistic to the class; they seek declaratory and injunctive relief which will inure to the benefit of all members of both the physician-class and the patient class; and, they are represented by counsel who are competent and experienced in civil rights litigation.

(e) The defendants, given their duty to enforce the MPA, the ASTC Act and the HFP Act, upon grounds generally applicable to the class, thereby make appropriate declaratory and final injunctive relief in favor of the plaintiff classes.

IV. DEFENDANTS

18. Bernard J. Turnock is the Acting Director of the Department of Public Health of the State of Illinois and is sued in his official capacity. He is responsible for the promulgation and enforcement of regulations under the ASTC Act and the HFP Act.

19. Neil F. Hartigan is the Attorney General of the State of Illinois and as such is the chief law enforcement officer of the State of Illinois. He is charged with the enforcement, implementation, administration and defense of the MPA, the ASTC Act, the HFP Act, and their respective regulations, throughout the State of Illinois. Defendant Hartigan is sued in his official capacity as Attorney General of the State of Illinois, and unless restrained by the orders of this Court, will perform his duties to ensure the enforcement of the MPA, the ASTC Act, and HFP Act.

20. Richard M. Daley is the Illinois State's Attorney for Cook County, and as such is charged with the enforcement, implementation, administration and defense of the MPA, the ASTC Act, the HFP Act, and their respective regulations, throughout Cook County, Illinois. Defendant Daley is sued in his official capacity as State's Attorney of Cook County, and as the representative of the defendant class of all State's Attorneys of the 101 counties of the state of Illinois ("the State's Attorneys' class"), pursuant to Rules 23(a) and (b)(2) of the Federal Rules of Civil Procedure.

21. The State's Attorney's class is so numerous that joinder of all members is impracticable. Substantial questions of law are common to the class and the defenses of defendant Daley are typical of the defenses of the class. Defendant Daley has had substantial experience defending class action lawsuits involving challenges to Illinois statutes regulating abortion and will fairly and adequately represent the interests of the defendant class.

22. Gary L. Clayton is the Director of the Illinois Department of Registration and Education, and as such is empowered to implement, administer and enforce the MPA. Defendant Clayton is sued in his official capacity.

V. STATUTORY FRAMEWORK

23. The Illinois General Assembly has enacted three separate, but inter-connecting, statutes governing licensed physicians and the performance of abortion: (1) the Illinois Medical Practice Act ("MPA"), Ill. Rev. Stat. ch. 111 § 4433; (2) the Ambulatory Surgical Treatment Center Act ("ASTC Act"), Ill. Rev. Stat. ch. 111½ § 157-8.1 to § 157-8.16; and (3) the Health Facilities Planning Act ("HFP Act"), Ill. Rev. Stat. ch. 111½ § 1151 to § 1168. These statutes, applied together, form a complex regulatory structure which, in effect, requires that all abortions performed in Illinois, even those performed during the first trimester and early second trimester of pregnancy, be performed in a full-service, tertiary care hospital or its functional equivalent—an ambulatory surgical treatment center.

A. THE MEDICAL PRACTICE ACT

24. The MPA sets up the regulatory system for the licensing of all physicians in the state of Illinois. Section 16-1 of the MPA (Ill. Rev. Stat. ch. 111 § 4433) authorizes the Director of the Illinois Department of Registration and Education to suspend or revoke the license of any Illinois physician who performs an abortion in any place other than a hospital or an ambulatory surgical treatment center. Thus, a physician wishing to perform an outpatient elective first trimester abortion must perform that procedure in an ambulatory surgical treatment center or risk suspension or revocation of his license and disruption of his professional livelihood.

B. THE ASTC ACT

25. The ASTC Act provides the next layer of restrictive regulation of abortions and governs the establishment

and operation of ambulatory surgical treatment centers. Section 3(a) of the ASTC Act defines an ambulatory surgical treatment center as "any institution, place or building devoted *primarily* to the maintenance and operation of facilities for the performance of surgical procedures or *any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose. . . .*" Ill. Rev. Stat. ch. 111½ § 157-8.3. (Emphasis added.)

26. The ASTC Act and the regulations promulgated by the IDPH pursuant to authority granted by the ASTC Act, impose hundreds of regulations upon the operation of ambulatory surgical treatment centers, including those centers which perform abortions.

27. Many restrictions promulgated under the ASTC Act single out for different and discriminatory treatment facilities in which abortions are performed. These abortion-specific regulations include but are not limited to the following:

(a) Section 6.1 of the ASTC Act and Section 205.120 (b)(9)(F) of the ASTC Act regulations require *only* facilities in which abortions are performed to employ, as a condition of licensing, "a physician with a license to practice medicine in *all* of its branches and [who] is actively engaged in the practice of medicine at the Center, . . ." (Emphasis added.)

(b) Section 205.540 of the regulations, requires patients who have had general anesthesia, local anesthesia or a "*pregnancy termination*" to be subject to special observation requirements.

(c) Subpart G of the regulations singles out and focuses upon facilities in which abortions are performed. The burdensome restrictions imposed by these regulations include a prohibition upon performing abortions after the 12 weeks gestational age, reporting requirements for each abortion procedure performed, and vaguely defined nursing requirements.

28. The physical plant and mechanical system requirements that the ASTC Act and its regulations impose upon facilities performing abortions require such facilities to be the equivalent of a small hospital with respect to required equipment, procedure room size, details and finishing, air-conditioning, heating and ventilation operations, and plumbing facilities. These requirements regulate every aspect of the operation of an abortion facility. These regulations include, but are not limited to, the following:

(a) Regulation 205.1320(a), requires an ASTC to be "identifiably separate" from other [medical] facilities and functions.

(b) Regulation 205.1330, requires anyone seeking to build or substantially remodel an ASTC to submit work plans to the state for prior approval. These work plans include architectural drawings, structural drawings, and mechanical drawings (which include drawings of the heating, cooling, ventilation, plumbing, drainage, stand-pipe and electrical systems).

(c) Regulation 205.1360(a), requires that an examination room be at least 80 square feet in size.

(d) Regulation 205.1360(b), requires that a procedure room have a minimum clear area of 250 square feet—almost the size of a hospital delivery room suite.

(e) Regulation 205.1370(a), requires an ambulatory surgical treatment center to have a "control station" located to permit "visual surveillance of all traffic which enters the operating suite".

(f) Regulation 205.1370(k), requires that "staff and personnel facilities be provided for male and

female personnel," including a lounge, lockers, separate toilets, and space for changing clothes.

(g) Regulation 205.1370(n), requires a separate janitorial closet exclusively for the surgical suite.

(h) Section 205.1380, requires an ambulatory surgical treatment center to establish a "diagnostic facility" equipped to perform diagnostic tests far more elaborate and complex than those performed during the course of a pregnancy termination.

(i) Regulation 205.1400 regulates the size of doors and halls to require that some corridors be at least 8 feet in width and that doors to procedure rooms be at least 3 feet 8 inches wide. These dimensions parallel the requirements for hospital corridors.

(j) Numerous other provisions regulate the number and placement of toilets to require separate toilet facilities for the public, patients, staff and the handicapped.

(k) Section 205.1540 regulates the air conditioning, heating, and ventilation systems to require (a) specific filter efficiencies and (b) air flow systems "balanced" to comply with the detailed ventilation and pressure relationships established by the regulation. Different pressure relationships and air change requirements are specified for the following areas: (1) the procedure room, (2) the examination area, (3) the recovery room, (4) the instrument cleaning room, (5) the toilet room, (6) the janitors' closet, (7) the linen and trash area, (8) the anesthesia storage area, (9) the equipment storage area, (10) the clean linen and storage area, (11) the soiled linen storage area, (12) the laboratory area, and (13) miscellaneous other areas.

29. Operation of a facility in which abortions are performed without first securing an ASTC license subjects the person(s) "operating, conducting or maintaining" the facil-

ity to a fine of $10,000. Ill. Rev. Stat. ch. 111½ § 157-8.12. Each day's violation constitutes a separate offense. Section 157-8.12 further directs that any person "opening, conducting, or maintaining an ambulatory surgical treatment center who violates any other provision of the [ASTC] Act [is] guilty of a business offense punishable by a fine of not more than $10,000."

30. The ASTC Act and its regulations, identified in ¶¶ 25-29, above, are not medically necessary for the performance of a safe first or second trimester abortion, depart from generally accepted medical practices, further no compelling state health interests, and are not narrowly drawn. The enforcement of these regulations, in conjunction with the MPA, the HFP Act and HFP regulations, imposes a significant and unconstitutional burden upon plaintiff-patients' exercise of their constitutional right to terminate their pregnancies. These restrictions are also vague, irrational, arbitrary and unreasonably restrictive of a physician's right to practice medicine. Further, these restrictions are vague, irrational, arbitrary and unreasonably restrictive of a clinic operator's right to operate a clinic.

C. THE HFP ACT

31. The Health Facilities Planning Act ("HFP"), Ill. Rev. Stat. ch. 111½ § 1152 to § 1168, and regulations promulgated thereunder, provide the final layer of the unnecessarily complex and intertwined system of abortion restrictions imposed by the state of Illinois.

32. IDPH interprets the HFP Act and its regulations to apply to all ambulatory surgical treatment centers, including those in which a single abortion is performed.

33. The HFP Act regulations mandate very detailed procedures for obtaining a permit to operate a "health care facility," which is interpreted by IDPH to include ambulatory surgical treatment centers. These procedures require a permit separate from that needed to operate an ambulatory surgical treatment center, require approval by affected state and federal health planning organizations, and require public hearings before the issuance (or denial) of a Health Facilities Planning Board Permit and a Certificate of Recognition.

(a) Without first securing the HFP Permit and Certificate of Recognition, a person desiring to establish or relocate a clinic in which abortions are performed will not be able to proceed with the licensing process established by the ASTC Act.

(b) Without these documents, a clinic operator will not be able to proceed with construction or remodeling of a facility in order to comply with the substantive plant and mechanical requirements established by the ASTC Act and its accompanying regulations.

34. Any person who constructs or modifies a health care facility without a permit issued under the HFP Act or in violation of the terms of the HFP permit is guilty of a business offense and may be fined up to $10,000.

35. The HFP Act and its regulations, as applied to outpatient facilities in which abortions are performed, are not medically necessary for the performance of a safe first or second trimester abortion, depart from generally accepted medical practices, further no compelling state health interest, and are not narrowly drawn. The enforcement of these regulations, in conjunction with the MPA, the ASTC Act and the ASTC regulations, place a significant burden upon plaintiff-patients' exercise of their con-

stitutional right to terminate a pregnancy. These restrictions are vague, irrational, arbitrary and unreasonably restrictive of a physician's right to practice medicine. Further, these restrictions are vague, irrational, arbitrary and unreasonably restrictive of a clinic operator's right to operate a clinic facility.

VI. CAUSE OF ACTION

36. The Northern Illinois Women's Center (the "Center") is the only facility providing first trimester elective abortions in a large area of northern Illinois and southern Wisconsin extending from Rockford north to Madison, Wisconsin (70 miles); south to Peoria (130 miles); east to Chicago (80 miles), and west to the Mississippi River (120 miles).

(a) Three thousand four hundred and eighty abortions were performed at the Center in 1984.

(b) Reduced fee or free abortion services are provided for indigent women.

(c) Fifty percent of the women patients receiving abortions at the Center are between the ages of 13-21.

(d) Many of the abortion patients at the Center lack the financial resources to travel to another medical facility to secure an abortion.

37. The Center is located in the city of Rockford, in the Medical Arts Building, which building is operated by the Rockford Services Company. Dr. Ragsdale currently leases office space within the Medical Arts Building.

38. The Center is currently licensed as an ambulatory surgical treatment center, and has been so licensed since 1973.

39. Dr. Ragsdale is the Director and owner of the Center and is solely responsible for its operation. He is personally responsible for the hiring, training and supervision of support personnel, the acquisition of medical equipment and the day-to-day operations of the Center.

40. In January, 1985, Rockford Services Company informed Dr. Ragsdale that his lease would not be renewed. Dr. Ragsdale was told: that remodeling the Medical Arts Building to construct a clinic that *fully* complied with the ASTC would be prohibitively expensive; and, that his premises are needed as office space for physicians who refer more patients to the hospital than does Dr. Ragsdale.

41. Dr. Ragsdale requested that Rockford Services Company reconsider its decision; however, the non-renewal was confirmed in May, 1985. Dr. Ragsdale has been advised that he must vacate his current premises by December 31, 1985.

42. Dr. Ragsdale has made extensive efforts to find space to relocate the Center. Dr. Ragsdale has been unable to locate new rental premises for the Center which would comply with the physical requirements imposed by MPA, the HFP Act and the ASTC Act and the accompanying regulations. Further, construction of a new facility, or renovation of existing space such that it would meet the regulations of the Act, would, in essence, require Dr. Ragsdale to build a small hospital.

43. For Dr. Ragsdale to build a new facility, or to renovate existing space in order to comply completely with the structural and operational regulations of the tripartite Illinois regulatory scheme would substantially increase the cost of gynecological, family planning and abortion services for women in northern Illinois and southern Wisconsin.

44. As a result of the Illinois regulatory scheme, Dr. Ragsdale will be unable to continue his medical practice of gynecological, family planning and abortion services after December 31, 1985. This event will significantly burden plaintiff-patients' right to choose to terminate undesired pregnancies, either by making abortion unavailable or too costly, or requiring additional travel time to a location away from their home and away from their physician.

45. The medical facility Ms. Moe owns in Cook County provides a full range of gynecological health care services for women, except abortions.

46. Many patients at Ms. Moe's facility have incomes at or below the poverty line. Her clinic provides gynecological services to these women at a reduced rate or, in some cases, free of charge.

47. Ms. Moe would like to offer abortion services to patients and employs several physicians who are willing to perform abortions and who are trained and qualified to perform such services for their patients at Ms. Moe's facility.

48. Ms. Moe's medical facility receives approximately 20-25 requests per week from women patients seeking to terminate pregnancies.

49. Ms. Moe's medical facility does not meet the physical, structural and administrative requirements of the ASTC and HFP Acts, and is not licensed as an ambulatory surgical treatment center. Thus, despite the availability of proper medical facilities and competently trained personnel, Ms. Moe cannot offer abortions to those patients seeking to terminate pregnancies without risk of violating the ASTC Act and incurring the $10,000 per day fine levied by Section 157-8.12 of that Act.

50. Ms. Moe would like to offer abortion services to patients at her medical facility. Her facility would be able to provide safe, medical abortions to patients seeking them. However, her medical facility does not comply with the physical plant and mechanical systems requirements of the ASTC Act, as enumerated in ¶¶ 26-28, above. To renovate her existing clinic or to construct a new facility that would comply completely with the ASTC Act would be prohibitively expensive since it would, in essence, require Ms. Moe to build a small hospital.

51. Because Ms. Moe's facility is not licensed under the ASTC Act, Ms. Moe's patients are forced to travel long distances from 50-100 miles to find a physician in a facility licensed as an ASTC, from whom they can secure safe, medical abortions.

52. Traveling long distances to have a medically safe abortion is a great hardship for many of Ms. Moe's patients.

(a) Approximately 60 percent of Ms. Moe's patients at the Cook County facility are young women between the ages of 13-20. Seventy percent of these young women are considered "without income" under federal guidelines and thus fall within the poverty level. These young women often lack the financial means to travel to secure an abortion.

(b) A large percentage of Ms. Moe's older patients also have limited financial means. Thirty to forty percent of these women lack means of personal transportation by which to travel to have an abortion.

53. For Ms. Moe to build a new facility, or to renovate existing space in order to comply completely with the structural and operational regulations of the tripartite Illinois regulatory scheme would substantially and unnecessarily increase the cost of gynecological, family planning and abortion services for women in Cook County and the adjoining counties.

54. As a result of the Illinois regulatory scheme, Ms. Moe has been unable to offer her patients needed abortion services. This significantly burdens plaintiff-patients' right to choose to terminate undesired pregnancies, either by making abortion unavailable or too costly, or requiring additional travel time to a location away from their home and away from their physician.

55. The tripartite regulatory scheme places a significant burden upon plaintiff-patients' exercise of their constitutional right to effectuate a decision to have an abortion, are not narrowly drawn, further no compelling state health objective, are not medically necessary and depart from medically accepted practices. These restrictions are vague, irrational, arbitrary and unreasonably restrictive of Dr. Ragsdale's right to practice medicine and of Ms. Moe's right to practice her profession and operate a medical facility.

56. As a proximate and a direct result of the MPA, the ASTC Act and its regulations, and the IDPH's application of the HFP Act and its regulations, plaintiffs have been irreparably injured and will continue to suffer irreparable injury.

57. Plaintiffs have no adequate remedy at law and this action for declaratory and injunctive relief is the only means for securing the relief requested.

VII. CLAIMS FOR RELIEF

A. PRIVACY

58. The MPA, the ASTC Act and its regulations, and the IDPH's application of the HFP Act and its regulations, place a significant burden upon the rights of Jane Doe, Sarah Roe, and other Illinois women similarly situated, including patients at Ms. Moe's facility, to choose to terminate first trimester and second trimester pregnancies and to effectuate such decisions free of interference from the state, in violation of the right of privacy as guaranteed by the First, Fourth, Fifth, and Ninth Amendments to the United States Constitution, the penumbras of the Bill of Rights, and the concept of ordered liberty protected by the Fourteenth Amendment to the United States Constitution and 42 U.S.C. § 1983.

B. EQUAL PROTECTION

59. The MPA, the ASTC Act and its regulations, the HFP Act and its accompanying regulations, individually and collectively, prevent Dr. Ragsdale and other physicians wishing to perform abortions from performing them in medical facilities available to other physicians performing medically analogous services, such as diagnostic dilations and curretage, insertion of I.U.D.s (intra-uterine devices), needle aspiration of breast cysts, vasectomies, uterine biopsies, conization, and tubal sufflations. Further, this statutory scheme prevents Ms. Moe from offering abortion services in medical facilities available for the performance of medically analogous services, such as diagnostic dilations and curretage, insertion of I.U.D.s (intra-uterine devices), needle aspiration of breast cysts, vasectomies, uterine biopsies, conization, and tubal sufflations.

60. The existence of the MPA, the ASTC Act, the HFP Act, their respective regulations, and the enforcement of these regulations by defendants, deprives Dr. Ragsdale and other physicians similarly situated of their right to practice medicine free from vague, arbitrary, irrational and burdensome regulations, which regulations are not imposed upon physicians practicing medically analogous procedures, in violation of their right to equal protection of the law as guaranteed by the Fourteenth Amendment to the United States Constitution and 42 U.S.C. § 1983. Further, this statutory scheme deprives Ms. Moe of her right to practice her profession and operate her facility free from vague, arbitrary, irrational and burdensome regulations, which regulations are not imposed upon other health care facilities offering medically analogous procedures, in violation of her right to equal protection of the law as guaranteed by the Fourteenth Amendment to the United States Constitution.

VIII. PRAYER FOR RELIEF

WHEREFORE, plaintiffs request that this Court grant the following relief:

A. Enter a declaratory judgment that Section 16-1 of the Medical Practice Act, Ill. Rev. Stat. ch. 111 § 4433, the Health Facilities Planning Act and its regulations as applied by the IDPH to regulate facilities in which first and second trimester abortions are performed, and the Ambulatory Surgical Treatment Center Act and its regulations, deprive plaintiffs Jane Doe, Sarah Roe and all Illinois women similarly situated, including Ms. Moe's patients, of their rights secured by the First, Fourth, Fifth, Ninth, and Fourteenth Amendments to the United States Constitution and 42 U.S.C. § 1983;

B. Enter a declaratory judgment that Section 16-1 of the Medical Practice Act, Ill. Rev. Stat. ch. 111 § 4433, the Health Facilities Planning Act and its regulations as applied by the IDPH to regulate facilities in which first and second trimester abortions are performed, and the Ambulatory Surgical Treatment Center Act and its regulations, deprive Dr. Ragsdale and all other physicians who may wish to perform abortions of their rights as secured by the Fourteenth Amendment to the United States Constitution and further, deprive Ms. Moe of her rights as secured by the Fourteenth Amendment to the United States Constitution and 42 U.S.C. § 1983;

C. Enter preliminary and permanent injunctions ordering defendants, their officers, agents, servants, employees, and attorneys and those persons acting in concert or participation with them, from enforcing, threatening to enforce, or otherwise applying said Acts or regulations in derogation of plaintiffs' rights; and further;

D. Award plaintiffs' attorneys' fees and costs and expenses pursuant to 42 U.S.C. § 1988; and

E. Award such other and further relief as this Court deems appropriate.

Respectfully submitted,

Alan S. Gilbert
Colleen K. Connell
Susan M. Kornfield

By /s/ ALAN S. GILBERT
One of the Attorneys
for Plaintiffs

OF COUNSEL:

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Chicago, Illinois 60606
(312) 876-8000

Roger Baldwin Foundation
of ACLU, Inc.
Suite 816
220 South State Street
Chicago, Illinois 60604
(312) 427-7330

DATED: June 28, 1985

STATE OF ILLINOIS
COUNTY OF WINNEBAGO—SS

VERIFICATION

I, RICHARD M. RAGSDALE, M.D., on oath state that I have read the foregoing Verified Complaint, and that the facts pleaded are true and correct to the best of my knowledge, information and belief.

/s/ RICHARD M. RAGSDALE, M.D.
Richard M. Ragsdale, M.D.

[Jurat omitted in printing]

[Caption omitted in printing]

ANSWER
(Filed August 30, 1985)

NOW COME Defendants, Bernard J. Turnock, Director of the Illinois Department of Public Health; Neil F. Hartigan, Attorney General of Illinois; and Gary L. Clayton, Director of the Illinois Department of Registration and Education, and submit the following in answer to plaintiff's complaint:

1. The allegations of paragraph (1) of the Complaint are legal conclusions which defendants are not required to either admit or deny.

2. The allegations of paragraph (2) of the Complaint are legal conclusions which defendants are not required to either admit or deny.

3. The allegations of paragraph (3) (a) and (b) of the Complaint are legal conclusions which defendants are not required to either admit to deny.

4. The allegations of paragraph (4) of the Complaint are legal conclusions which defendants are not required to either admit or deny.

5. The allegations of paragraph (5) are legal conclusions which defendants are not required to either admit or deny.

6. The allegations of paragraph (6) are legal conclusions which defendants are not required to either admit or deny.

7. Defendants lack sufficient knowledge to form a belief as to the veracity of the allegations of paragraph (7).

8. Defendants lack sufficient knowledge to form a belief as to the veracity of the allegations of paragraph (8).

9. Defendants lack sufficient knowledge to form a belief as to the veracity of the allegations of paragraph (9).

10. Defendants lack sufficient knowledge to form a belief as to the veracity of the allegations of paragraph (10).

11. Defendants lack sufficient knowledge to form a belief as to the veracity of the allegations of paragraph (11).

12. Defendants lack sufficient knowledge to form a belief as to the veracity of the allegations of paragraph (12).

13. Defendants lack sufficient knowledge to form a belief as to the veracity of the allegations of paragraph (13).

14. Defendants lack sufficient knowledge to form a belief as to the veracity of the allegations of paragraph (14).

15. Defendants lack sufficient knowledge to form a belief as to the veracity of the allegations of paragraph (15).

16. Defendants lack sufficient knowledge to form a belief as to the veracity of the allegations of paragraph (16).

17. The defendants lack sufficient knowledge to form a belief as to the truth of the legal conclusions set forth in the first three sentences of paragraph (17).

(a) The defendants lack sufficient knowledge to form a belief as to the truth of the allegation that in 1982 approximately 65,860 women in Illinois had abortions. The remaining allegations of paragraph 17(a) are legal conclusions which defendants are not required to either admit or deny.

(b) The allegations of paragraph 17(b) are legal conclusions which defendants are not required to either admit or deny.

(c) The allegations of paragraph 17(c) are legal conclusions which defendants are not required to either admit or deny.

(d) The allegations of paragraph 17(d) are legal conclusions which defendants are not required to either admit or deny.

(e) The allegations of paragraph 17(e) are legal conclusions which defendants are not required to either admit or deny.

18. The allegations of paragraph (18) are directed to defendant Dr. Turnock, who denies that he is the Acting Director of the Department of Public Health and states that he is the Director of the Department of Public Health. The remaining allegations are legal conclusions which Defendant is not required to admit or deny.

19. Defendant Hartigan admits that he is the Attorney General of the State of Illinois. Defendant Hartigan further states that his du'ies are as set forth in Art. V, Section 15 of the Constitution of the State of Illinois and by statute at Ill. Rev. Stat. (1983), ch. 14, Section 4. The remaining allegations of paragraph (19) are legal conclusions which defendant is not required to either admit or deny.

20. The allegations of paragraph (20) are not directed to these defendants.

21. The allegations of paragraph (21) are not directed to these defendants.

22. The allegations of paragraph (22) are directed to defendant Clayton, who admits that he is the Director of the Illinois Department of Registration and Education and that his duties are set forth in relevant statutes and regulations, which speak for themselves. The remaining allegations are legal conclusions which defendant is not required to admit or deny.

23. The defendants admit that the statutes cited in paragraph (23) were enacted by the Illinois General Assembly. The remaining allegations of this paragraph are

legal conclusions which defendants are not required to admit or deny.

24. Defendants admit that the Medical Practice Act regulates the licensing of physicians in Illinois. The remaining allegations of this paragraph are legal conclusions which defendants are not required to admit or deny.

25. The allegations of paragraph (25) are legal conclusions which defendants are not required to admit or deny.

26. The allegations of this paragraph are legal conclusions which defendants are not required to admit or deny.

27. The allegations of this paragraph are legal conclusions which defendants are not required to admit or deny.

28. The allegations of paragraph (28) are legal conclusions which defendants are not required to admit or deny.

29. The allegations of paragraph (29) are legal conclusions which defendants are not required to admit or deny.

30. The defendants deny the allegations of paragraph (30).

31. The defendants deny the allegations of paragraph (31).

32. The HFP Act and regulations speak for themselves and defendants neither admit nor deny plaintiffs' characterizations of same. Director Turnock affirmatively states that the Illinois Department of Public Health interprets the Act and Regulations in accordance with the law.

33. The regulations referred to in paragraph (33) of the complaint speak for themselves and defendants neither admit nor deny the plaintiff's characterization of those regulations.

34. The regulations and Act referred to in paragraph (34) speak for themselves and defendants neither admit nor deny plaintiffs' characterizations.

35. The defendants deny the allegations of paragraph (35).

36. The defendants lack sufficient knowledge to form an opinion as to the veracity of the allegations of paragraph (36).

37. The defendants lack sufficient knowledge to form an opinion as to the veracity of the allegations of paragraph (37).

38. The defendants lack sufficient knowledge to form an opinion as to the veracity of the allegations of paragraph (38).

39. The defendants lack sufficient information to form an opinion as to the veracity of the allegations of paragraph (39).

40. The defendants lack sufficient knowledge to form an opinion as to the veracity of the allegations of paragraph (40).

41. Defendants lack sufficient knowledge to form an opinion as to the veracity of the allegations of paragraph (41).

42. The defendants lack sufficient knowledge to form an opinion as to the veracity of the allegations of paragraph (42).

43. The defendants lack sufficient knowledge to form an opinion as to the veracity of the allegations of paragraph (43).

44. The defendants lack sufficient knowledge to form an opinion as to the veracity of the allegations of paragraph (44).

45. The defendants lack sufficient knowledge to form an opinion as to the veracity of the allegations of paragraph (45).

46. The defendants lack sufficient knowledge to form an opinion as to the veracity of the allegations of paragraph (46).

47. The defendants lack sufficient knowledge to form an opinion as to the veracity of the allegations of paragraph (47).

48. The defendants lack sufficient knowledge to form an opinion as to the veracity of the allegations of paragraph (48).

49. The defendants lack sufficient knowledge to form an opinion as to the veracity of the allegations of paragraph (49).

50. The defendants lack sufficient knowledge to form an opinion as to the veracity of the allegations of paragraph (50).

51. The defendants lack sufficient knowledge to form an opinion as to the veracity of the allegations of paragraph (51).

52. The defendants lack sufficient knowledge to form an opinion as to the veracity of the allegations of paragraph (52).

53. The defendants lack sufficient knowledge to form an opinion as to the veracity of the allegations of paragraph (53).

54. The defendants lack sufficient knowledge to form an opinion as to the veracity of the allegations of paragraph (54).

55. The defendants deny the allegations of paragraph (55).

56. The defendants deny the allegations of paragraph (56).

57. The defendants deny the allegations of paragraph (57).

58. The defendants deny the allegations of paragraph (58).

59. The allegations of paragraph (59) are legal and factual conclusions which defendants neither admit nor deny.

60. The defendants deny the allegations of paragraph (60).

61. Defendants deny each and every allegation of Plaintiff's Complaint which has not been responded to heretofore.

AFFIRMATIVE DEFENSES

1. The plaintiffs have failed to state a claim upon which relief may be granted.

2. The plaintiffs have failed to exhaust their administrative remedies.

3. Plaintiffs lack standing to pursue this action.

WHEREFORE, defendants Turnock, Hartigan and Clayton respectfully pray that this Honorable Court deny plaintiffs the relief requested or any other relief whatsoever and ask that this action be dismissed with prejudice and costs and attorneys fees to be awarded to defendants.

Respectfully submitted,

/s/ KATHLEEN T. KREISEL
Kathleen T. Kreisel
Gladys Stevens
Assistant Attorneys General
General Law Division
(312) 917-3654

Neil F. Hartigan
Attorney General of Illinois
100 W. Randolph, 13th Floor
Chicago, IL 60601

PLAINTIFFS' EXHIBIT NO. 16

(Letterhead Of)

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Thomas B. Kirkpatrick, Jr., Director
535 West Jefferson Street
Springfield, Illinois 62761
Telephone 217-782-4977

MEMORANDUM

DATE : February 27, 1985
TO : Director Kirkpatrick
THRU : Channels
FROM : Jack Wilson
SUBJECT : Certificate of Need Requirements

We believe that some provision should be made to allow the Health Facilities Planning staff to issue a letter of exemption when the licensee of an Ambulatory Surgical Treatment Center moves the Center from one premises to another within the same municipality provided the new premises meets all of the physical plant licensing requirements.

Why require a full CON application when there is *no* increase in the number of facilities; no change in ownership; no change in services provided and no change in the city and the former location vacated and adequately documented that it will no longer be utilized as an ASTC.

The case in point is NORTHERN ILLINOIS WOMENS CENTER, LTD., 2500 North Rockton Avenue, Rockford, Illinois 61103, with Richard M. Ragsdale, M.D., the licensee. Doctor Ragsdale is vacating the present premises

to move into a premises that will meet the Department's life safety code requirements.

Your consideration of this request will be appreciated and in my opinion do a lot of good as far as public relations is concerned.

cc: Division Chief
Associate Director - OHR
Jim Linder
Dr. Ragsdale

Basic Cost of Move -

Require 3,600 sf.

base cost. ~~.05~~ $5.50/sf/yr = $19,850/yr.

Remodelling Expense.

HVAC Plumbing Partition Ceiling Electric Demolition Doors Cabinetry/millwork		98,000
Floor Wall Security Glazing Architect Phone, el Movers	8,000 floor 5,000 wall 2,500 5,000 3,000 500 2,000	26,000
	26,000	124,000
Interest		24,200
Total		148,200

Paid in 2 yr = 74,100/yr = 22.45/pv.

Extra above basic cost:

1) 1500 Ft space @ .055/y = 8,200/y.

2) Remodelling (2yr)
1500 // @ #30/ft = 45,000

HVAC extra	15,000
Plumbing	5,000
Doors, etc	2,500
Ceiling	2,500
Architect	5,000
	75,000

Interest-2y @ 13% 19,500

Total 94,500 = 47,250/y

3) Elevator. (5yr) 75,000
50-100,000 (use 75,000)
Interest. 48,750
123,750 = 24,750/y

4) Extra operating cost. 3,000/y

Total Extra /y = #83,200

@ 3,300 pt = #25.21/pt.

PLAINTIFF'S EXHIBIT 28

PLAINTIFFS' EXHIBIT NO. 22

MINUTES
AMBULATORY SURGICAL TREATMENT CENTER
LICENSING BOARD MEETING
FIRST FLOOR CONFERENCE ROOM
1130 SOUTH SIXTH STREET, SPRINGFIELD
MARCH 7, 1974
10:00 A.M.

Board Members present:

Robert E. Bowen, M.D.
James E. Coeur, M.D.
Edward Jesse Jacobs, M.D.
Gwendolyn Boyd Schmidt, M.D.
Marion Etten, R.N.
James R. Cook, Ph.D.
Ruth Surgal

Board Members absent:

E. Wynn Presson
Robert L. Ewbank, D.D.S.

Staff present:

Joyce C. Lashof, M.D.
R. S. Gleason
Paul X. Elbow
Robert F. Bilstein
Dorothy Flackus, Secretary

Guest present:

Shirley Scism, Governor's Office

The meeting was called to order by Mr. Paul X. Elbow, Chief, Division of Health Facilities, and introductions were made. Mr. Elbow was selected to serve as Acting Chairman for this meeting. The permanent Chairman for the Board will be elected at a subsequent meeting.

Mr. Elbow read Section 14 of the Act. Mr. Elbow and Mr. Gleason reviewed events leading to the development of the interim Ambulatory Surgical Treatment Center Licensing Requirements.

The development of standards for ambulatory facilities not licensable has been going on for a period of several years. Not specifically for abortion centers and not specifically for ambulatory surgical treatment centers but we were considering a very encompassing licensure classification that included possibly 30 other categories of ambulatory facilities. Prior to this legislation the state law only regulated three or four kinds of health facilities. The Hospital Licensing Act, of course, regulates hospitals. Long term care facilities are licensed as are independent laboratories and blood banks.

Without the public interest in abortions we would not have any of the present legislation. The legislation was written specifically for regulation of the performance of abortions. The standards were written for ambulatory surgical treatment centers and abortion clinics are considered as such and there are special provisions relating to the performance of abortions. There has been a lot of misunderstanding as indicated by the mail and comments we have had. The Department of Public Health was required to prepare regulations to implement the law and of course we had to burn a lot of midnight oil because this legislation became effective on signing by the Governor. With all the interest and activity that was going on, we were fortunate in having done a lot of work on preparation of standards over the past few years.

The preparation of the licensing requirements for ambulatory surgical treatment centers has had the input of all the professional groups. You might question the input—whether the right people represented the right organization. Occasionally you can say we missed an organization but that don't happen very often. The regulations do not just reflect the Department's ideas. They represent a state action with the involvement and participation of everybody concerned.

It is standard procedure in the Hospital Licensing Board activities to have a member of the Board be the Chairman of any committee, and we have committees ongoing all the time to constantly revise hospital regulations. The committee consists of experts like you people. Hospitals do not have to meet these requirements per se. We already have an entire set of regulations. Hospital licensing regulations are written to encompass all the activities of the hospitals. They have to give us evidence of a program, policies and procedures for any service they render. Essentially, we would expect the quality of the service to always be good but as far as the regulations specifically being applicable to the hospital, they do not need a separate license to do abortions in the first trimester and they have always done therapeutic abortions.

The Department was by chance prepared to prepare regulations of things that had happened two years previous. We came out with what were tentative regulations and circulated these to all facilities that we were aware of in August 1973. The interim regulations did not have the full force of law that we would like for them to have had because this Board was not appointed. They have not been approved by this Board, but at least they were standards. They are the interim Ambulatory Surgical Treatment Center Licensing Requirements which have been used and are being used in evaluating the present operating facilities or facilities being established. These are the requirements we are starting with today. It is not by any means the definitive document that we hope it will eventually be.

The Director was charged with the responsibility of the law. It was necessary that she do something to start implementing this program.

Mr. Bilstein reviewed the development of the regulations. In July 1971, Dr. Lees, a member of the Hospital Licensing Board, was appointed Chairman of a Committee appointed to formulate regulations for those facilities that were presently unlicensable. Consideration was given to a large number of classifications and actually there were

32 types of health facilities listed. As the result of their work, regulations were developed which were more broad and not as specific as those we will review today. On July 12, 1972, the final draft (after four drafts) of proposed standards were submitted to the Hospital Licensing Board. Dr. Lees reviewed the proposed standards and answered questions. Two changes were made in the copy of the final draft. The following is recorded in the minutes of the Hospital Licensing Board Meeting: "After discussion, the following motion was made: Dr. Lees moved and Mr. Abrahamson seconded that the fourth draft as revised by the Committee on the development of standards for various classifications of free standing health facilities not now licensable under the Hospital Licensing Act be approved and the staff be mandated to use these guidelines upon request. In addition, that the Director be requested to obtain information as to the legality of presenting this authentically as an amendment to the Hospital Licensing Act or explore additional ways to make this a statutory requirement, but it is preferred that these regulations be a part of the present Hospital Licensing Act and Requirements." Motion carried.

Following that approval, on August 16, Mr. Elbow through the Bureau Director, Dr. Flashner, to Fred Uhlig, Legislation Liaison, General Administration, sent these proposed regulations forward.

About August 1972, we began to get involved more with the question of abortions which became the primary target for discussion. Then came the legislation which Mr. Gleason has discussed. There were selected staff members and representatives from different organizations formed into a committee which worked up the standards which we presently have which were put into effect by the Director as interim standards.

You were mailed a copy of the letter that went out on August 7, 1973 to all Illinois physicians which in effect gives you the capsule information in reference to all the Acts. Also you were mailed a copy of the memo that went

to all hospitals which essentially contained the same information and attached to that memorandum were some forms for reporting abortions. You also received copies of Public Acts 225, 226, 227 and 228. We are going to be primarily concerned with Public Act 78-227. You have been given a statistical report which was published in December which gives an analysis of the 5,478 abortions that were reported from the period September 1 to December 31, 1973. We will not be using the report in our discussion today but wanted to call it to your attention.

There was considerable discussion with questions and answers pertaining to the history of the enactment of the legislation and the development of the licensing requirements which has not been recorded.

The review of the interim Ambulatory Surgical Treatment Center Licensing Requirements provoked considerable discussion and debate.

Mr. Gleason reviewed the process of promulgation and what was accomplished by the Board at this meeting. We have a set of standards, knowing quite well they are not the definitive standards that this Board may desire or feel is necessary. They are a set of standards this Board can approve today and recommend to Dr. Lashof as being the first official regulations of the Department for Ambulatory Surgical Treatment Centers.

Dr. Lashof suggested approval of the interim licensing requirements as amended with whatever other sematic corrections necessitated by the amendments to be made by the staff.

The Ambulatory Surgical Treatment Center Licensing Requirements were approved with the revisions as indicated in the attached copy.

PLAINTIFFS' EXHIBIT NO. 24

MINUTES OF SPECIAL MEETING
AMBULATORY SURGICAL TREATMENT CENTER
LICENSING BOARD
Ground Floor Hearing Room
525 West Jefferson Street
Springfield, Illinois
June 19, 1984

Members Present:

Herbert Natof, M.D.
Dale H. Rosenberg, M.D.
Donald Hugar, D.P.M.
Brenda Harrison
representing Robert A. Colantino, D.D.S.
Frank A. Salvino
Peggy Montes
Caryl Towsley Moy, Ph.D.
Theresa F. Cummings
Frederick Weiss, M.D.

Members Absent:

Robert M. Swartz, M.D.
Laura K. Moody, R.N., B.S.N.

Department Staff:

Fred H. Uhlig
Jerry Ackerman
William A. Irvine
William Wheeler
Jack Wilson
Mary L. Lowe
Robert F. Bilstein
Marcella Woods, R.N.
Dorothy Adams

The meeting was called to order by William A. Irvine at 10:20 a.m. Mr. Irvine expressed his appreciation to the Board for taking the time to attend this special meeting. Mr. Irvine noted that Director Uhlig planned on being at the meeting. He was involved with appropriation hearings and asked that the discussion proceed.

Then Mr. Irvine introduced Mr. Bill Wheeler, Chief Legal Counsel, who will be sitting in for the Director, Ms. Mary Lowe from the Department Legal Staff, Mrs. Dorothy Adams, Division Secretary, and Jack Wilson, Bob Bilstein, Marcella Woods, and a guest, Mr. Larry Boress of the Medical Society. Mr. Irvine then asked the Board members to identify themselves.

It was stated that the purpose of the *Special Meeting* was to discuss and perhaps come up with a definition of "What is an Ambulatory Surgical Treatment Center?" and what makes it subject to licensure by our Department as an ASTC. That opened a lengthy discussion.

Mr. Irvine stated that there have been some tremendous changes in the concept of *Out-Patient Services* and the way health care services are being delivered. Some of these changes have an impact on the question of what is an ASTC. In the past, when the Department of Public Health was contacted by an agency wishing to be licensed as an Ambulatory Surgical Treatment Center, we would supply them with copies of our standards and give consultation. We would do a survey and if the facility met our requirements, then the facility or organization would be licensed as an ASTC. We did not actively seek out entities operating as unlicensed ASTCs. We did not have any means nor did we anticipate that there was a big problem with unlicensed centers. We also took the position that a physician or group of physicians with their own practice were under their own practitioner license and were basically outside the Ambulatory Surgical Treatment Center Licensing Act. Recently it has been brought to our attention there may be entities or organizations within the State of Illinois that are providing Out-Patient services and surgeries that might be subject to the ASTC

License Act although they historically have represented a physician's office or group practice. We have taken a position historically that because of the definition in the law that says an institution, place or building devoted primarily to the maintenance and operation of etc., etc. that some measure of the surgery is that considered an Ambulatory Surgical Treatment Center. Director Uhlig feels that this is a very important question and that decision must be made as to what is an Ambulatory Surgical Treatment Center. Also, who will be subject to licensure by our Department as an Ambulatory Surgical Treatment Center.

The federal government under the Medicare program has taken a somewhat different position in that their regulations, an Ambulatory Surgical Treatment Center must be devoted *exclusively* to surgery. Now what Director Uhlig would like for us to do today is to have some open discussion and some dialogue on this question. Mr. Irvine noted that a packet of information you have was available which contained the Federal definition, the definition from the law, information from the Joint Commission on Accreditation, information supplied by Dr. Weiss, and a letter from Frank Salvino. Also, an article that has been published by both Mr. Salvino and Dr. Hugar was included.

Dr. Hugar stated that the thing that bothers him is its percentage figure. He stated that in podiatry there are really little minor out-patient procedures, i.e., a simple little ingrown toenail that could be considered surgery. That would not be fair. If a dentist performing an extraction is a surgical procedure and if he did that 100% of the time, I don't think that should qualify him for application for a surgical center. I would hate to see us give direction to an investigator saying that if they go 35% then we should do this or that; I think that's the wrong way to go.

Mr. William Wheeler, the Department's Chief Legal Counsel, commented on the definition from the statute and that it was not very useful. The option to follow the 50% definition is one approach. We could take it upon ourselves

to reword the definition in the rules. Also, we could go to the legislature for a change in the law. We don't want to regulate every physician's office in the State. But we do need to draw the line. The Department needs the Board's advice.

Dr. Natof remarked that it was still unclear to him as to the problem; what is it?

Mr. Irvine explained that in the past, the law dealt with those facilities who came to us and said they would like to be licensed. Also the law states that this is not a voluntary activity. The law says that if you meet the definition, you must be licensed; not if you want to be licensed. It spells out that you have to be licensed.

Mr. Wheeler spoke about complaints received by the Department and that a specific entity which is not licensed as an ASTC does perform surgery. We investigated the complaint to see if they met the definition. It could become difficult to force this type of entity to become licensed if we use the current definition.

Outpatient surgery was then discussed. There seems to be a very broad definition of surgery.

Dr. Natof commented that two organizations, both very knowledgeable, were not consulted. Dr. Natof then recommended that one fruitful approach would be to try to identify all the characteristics that have been used to define a free-standing ASTC by all sources. Once we have made such a list, then try to select those characteristics that would be most applicable in deriving at a definition for the purposes of the Department of Public Health. He did say that he didn't think you will be able to define ASTC in one sentence or in one paragraph, because no one has ever been able to do that. By listing the characteristics, there are six, seven, eight or nine that individuals have used in defining ASTC's and it is a question of picking a right combination. The Feds chose one route and their definition was designed specifically for economic reasons. They don't want to reimburse for services in doctors' offices. Their definition may have components useful to us.

Mr. Wheeler asked if we attempt to define surgery should it include the time of those visits to the doctor's office before and after surgery.

Dr. Natof suggested we use the historical approach founded by Dr. Wally Reed, in Phoenix, Arizona. His theory is: (1) An ASTC was a facility that was devoted exclusively to surgery (Go back to what Dr. Weiss proposed at the last meeting.) The real concept was that it was a facility exclusively devoted to the performance of surgery in its broadest sense. Secondly, it was geographically and administratively physically separate from a doctor's office and a hospital. You can't take one section and "knight" it. Thirdly, patients know there is no overnight care. Patients are discharged the same day they have their surgery. Fourthly, that it was appropriately staffed and equipped to perform its mission.

Dr. Natof added that there is one other component that he feels very strongly about and that is the services of this facility should be available to all qualified practitioners who apply to use the facility (with stressing qualified). The State has already gotten into some trouble identifying "qualified." Must they be on the Medical Staff?

Mr. Wheeler asked two broad questions: (1) What can we do under the regulatory statute? (2) All constraints aside, how would the Board like to rewrite the Act?

Mr. Salvino stated that the Hospital Board has the responsibility for all that is done in the hospital. I think our Consulting Committees in our organizations should have equivalent authority. There are certain characteristics that should be present. If they are acting within those provisions and are not licensed, they are outside the law.

Mr. Irvine commented that if a physician or group of physicians wish to provide certain surgical procedures within their own office but do not meet the definition of "devoted exclusively to" say 50% of their time is devoted to surgery, they have a closed shop and under this definition they would not be an ASTC. Looking at that based

upon our current definition, the ASTC Licensing Act was to protect the health of the citizens of Illinois. If you have 50% surgery, but not licensed and not regulated, it could present a problem. We don't want to license physician's offices under this Act, but at the same time, we want to meet the requirements of this Act.

At this point, Fred Uhlig, Acting Director, and Jerry Ackerman, Associate Director, Office of Health Regulation, arrived from their budget hearing meeting. Mr. Irvine introduced them and proceeded to brief them on what had taken place so far.

The discussion regarding physicians' offices resumed. Mr. Wheeler commented that if we assumed we could delete "primary" and substitute "exclusively," would the Board want the law to read that way?

Dr. Natof brought up the fact that the law that was passed, specifically excludes dentists and oral surgeons and they probably do more surgery than anyone. This concern was discussed along with the fact that dentists/oral surgeons use anesthetic and there is definitely a need for resuscitation equipment in dentists' offices.

Fred Uhlig commented that the original legislation was passed to license abortion centers. Now we need a clear definition because of all the surgery being done in these centers and physicians' offices.

Fred Uhlig related the fact that a certain situation brought this problem to light. This one situation may bring other controversial issues that need to be defined. So what is needed is a very clear definition as to who you are and what you are. Mr. Uhlig stated that the Board could give him a recommendation of "no recommendation," if the Board is comfortable with the way the Department is functioning. Or, we can write up, in some form, a proposed rule including rewording and send it to the Board for comments. We could finalize an amendment to the law and send it through the proper channels.

Mr. Salvino suggested we look at the anesthetic, local and general, procedure and that may be a dividing line; however, so much is given in doctors' offices. Dr. Moy was in agreement with this. She thought anesthetics should definitely be included.

Again, Mr. Salvino commented that when we look at the total Act, he would like to see more written concerning the approach of the Consulting Committee, to be equivalent to what one would expect of the Hospital Governing Board in a hospital.

After some discussion on future problems that we will have to deal with, such as emergency centers, mobile units sponsored by hospitals, etc., Mr. Irvine announced to the Board that within the next 15 days, we will send the minutes of this meeting and some sort of proposed rule to the Board for comment. We will be looking internally at some of the questions raised.

Fred Uhlig said that he wanted to personally thank the Board for attending and for understanding the problem. He appreciated it very much!

The next meeting date is September 5, 1984, in Chicago at the Richard Daley Center.

The meeting adjourned at 11:55 a.m.

DEFENDANTS' EXHIBIT NO. 2

MEMORANDUM

Date: June 29, 1981

To: William L. Kempiners
Jerry Ackerman
M. S. Grobsmith
R. F. Bilstein

From: Michael C. Anderson
Legal Advisor

Subject: Ambulatory Surgical Treatment Center (ASTC) Act

Attached is a copy of the Opinion in *Village of Oak Lawn v. Marcowitz* issued by the Illinois Supreme Court last Friday. The Court declared a portion of the statutory definition of an ASTC unconstitutional and remanded the remainder of the case for trial. This statute is at *Ill.Rev. Stat.* 1979, ch. 111½, par. 157-8.3(A) and states:

> " 'Ambulatory surgical treatment center' means any institution, place or building devoted primarily to the maintenance and operation of facilities for performance of surgical procedures *or any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose.*" (Emphasis added)

The unconstitutional provision is underlined.

Accordingly, from now on in all licensure and enforcement proceedings an ASTC is officially *only* those facilities "devoted primarily . . . for performance of surgical procedures." Surveyors and members of the ASTC Advisory Board should be so notified.

1153o

DEFENDANTS' EXHIBIT NO. 6

Standards

for Obstetric-Gynecologic Services

Sixth Edition

The American College of
Obstetricians and Gynecologists

* * * * *

Quality obstetric-gynecologic care requires efficient organization of the medical staff and other personnel, whether the care is provided within an ambulatory or a hospital setting.

AMBULATORY CARE

Ambulatory obstetric-gynecologic care may be provided in a physician's office, outpatient clinic, or freestanding or hospital-based surgical facility. The organization of the ambulatory care facility varies, depending on the kind of facility or type of practice and on the patient volume. Certain standards are applicable to all types of settings, however.

Personnel directly involved in the welfare of obstetric and gynecologic patients should be organized into a health care team under the direction of an obstetrician-gynecologist. A sufficient number of staff members should be available to prevent undue delays, and they should possess the appropriate skills to provide optimal care. Job descriptions and written policies should be prepared and reviewed periodically. These policies should indicate specific responsibilities, as well as a plan for continuing education of personnel.

A freestanding ambulatory surgical facility should have a governing body, similar to a hospital board of trustees, that has final authority and responsibility for patient care, facilities, services, appointment of the medical staff, and delineation of clinical privileges. A mechanism similar to that used in the hospital for granting privileges should be established. Privileges granted to a physician should not exceed those held by that physician in at least one accredited hospital within the geographic area. A hospital-based facility usually functions under the hospital's governing body, and staff privileges in such a facility are established by hospital regulations.

Details on the way in which a freestanding or hospital-based ambulatory facility should be organized and the relation of the hospital staff to the facility are available from

the Joint Commission on Accreditation of Hospitals and the Accreditation Association for Ambulatory Health Care, Inc.

* * * * *

SURGICAL SERVICES

Certain surgical procedures may be performed on an ambulatory basis to conserve time and expense for the patient and to use hospital facilities efficiently. A physician's office, an outpatient clinic, or a free-standing or hospital-based ambulatory surgical facility may be used. Procedures should be limited to those that can be performed safely within the constraints of staff expertise and physical facilities. If the patient has a major medical disorder, appropriate consultation should be obtained before proceeding with a surgical procedure in an ambulatory facility.

Informed consent should be obtained before any surgical procedure is performed. Upon discharge, the patient should be given adequate postoperative instructions, preferably written, and arrangements should be made for routine and emergency follow-up care. The importance of a follow-up evaluation should be stressed during both the preoperative and postoperative interviews.

Removed tissue should be submitted to a pathologist for examination. The patient should be informed of the operative findings, including the results of the tissue examination. After an elective termination of pregnancy, the attending physician should record a description of the gross products. Unless definite embryonic or fetal parts can be identified, the products of elective interruptions of pregnancy should be submitted to a pathologist for gross and microscopic examination.

PHYSICIAN'S OFFICE AND OUTPATIENT CLINIC

Only surgical procedures that can be performed either without anesthesia or with only local anesthesia may be performed in the physician's office or in an outpatient clinic. When local anesthesia is used in these settings,

equipment and qualified personnel should be available for emergency resuscitation.

Procedures commonly performed in a physician's office or in an outpatient clinic include, but are not limited to, the following:

- Abortion, uncomplicated, up to 14 weeks from last menstrual period
- Aspiration of a breast cyst
- Biopsy, aspiration, or washing of the endometrium
- Cervical polypectomy
- Cervical, vaginal, and vulvar biopsies
- Colposcopy
- Cryosurgery, fulguration, or vaporization of the cervix or vulva
- Culdocentesis
- Cystometric studies
- Cystoscopy
- Dilatation and curettage
- Hysterosalpingography
- Hysteroscopy
- Incision and drainage of vulvar or perineal abscesses
- Evacuation of incomplete abortions, spontaneous and uncomplicated
- Insertion of intrauterine contraceptive device
- Proctosigmoidoscopy
- Removal of skin lesions
- Tubal insufflation
- Urodynamic studies
- Uterine sounding

FREE-STANDING AND HOSPITAL-BASED FACILITIES

Ambulatory surgical facilities that are free-standing or hospital-based should maintain the same surgical, anesthetic, and personnel standards that hospitals do. Surgical procedures may be performed in these facilities under general or regional block anesthesia when the postoperative recovery is expected to permit discharge on the same day.

Procedures commonly performed in a free-standing or hospital-based ambulatory surgical facility include, but are not limited to

- Breast biopsy
- Colpotomy
- Examination under anesthesia
- Extensive biopsies or extensive fulgurations of vulvar lesions
- Laparoscopy, including diagnostic procedures, tubal sterilization, or other surgical procedures if laparotomy is not anticipated
- Marsupialization of a Bartholin duct abscess or cyst
- Minilaparotomy for sterilization
- Simple perineoplasty
- Cervical conization

Those procedures performed in the physician's office or the outpatient clinic also may be performed in these facilities. There should be a written policy providing for prompt emergency treatment or hospitalization of patients in the event of an unanticipated complication.

A qualified anesthesiologist, another qualified physician, or a certified nurse-anesthetist under the supervision of an anesthesiologist, may administer general epidural or spinal anesthesia in an ambulatory surgical unit. When any form of anesthesia is used, trained personnel and proper equipment for cardiopulmonary resuscitation should be available. A physician, preferably the anesthesiologist, should be present in the ambulatory surgical facility until all patients have been discharged. This physician should oversee the postanesthetic recovery area and should share with the surgeon responsibility for discharging patients or transferring them to the back-up hospital.

Only a patient at low risk should be considered for ambulatory surgery. A preoperative history and physical examination should be completed no more than 2 weeks before the surgical procedure is to be performed. Preexisting or concurrent illness, medications, and adverse drug reactions that may have an effect on the operative pro-

cedure or anesthesia should be identified. Laboratory data should include hemoglobin or hematocrit, urine screen, and, in selected patients, other studies such as a chest x-ray, eletrocardiogram, and determination of electrolyte levels. The patient should be given preoperative instructions, especially regarding the restriction of food and fluids, and advised that noncompliance can result in cancellation of the procedure.

On the day of surgery, a preanesthetic evaluation, including an interval history, medical record review, and heart and lung examination should be performed by a physician, and the findings should be noted in the record.

A recovery area is necessary. During the recovery period, a member of the health care team should observe the patient continuously. This person should maintain a complete record of the patient's general condition, including vital signs, blood loss, and occurrence of complications. The patient should remain in the area until recovery is sufficient to permit safe discharge in the company of a responsible adult.

Upon discharge, the patient should be given instructions about medications, her follow-up care, the signs and symptoms of common complications, and how to obtain emergency care and advice.

ABORTION

Ambulatory care facilities for abortion services should meet the same standards of care as for other surgical procedures. Physicians performing abortions in their offices should provide for prompt emergency treatment or hospitalization in the event of complication. Clinics and freestanding ambulatory care facilities should have written agreements with nearby hospitals for the transfer of patients requiring treatment for emergency complications in abortion procedures.

Generally, abortions in the physician's office or outpatient clinic should be limited to those performed within 14 weeks from the first day of the last menstrual period.

In a hospital-based or free-standing surgical facility, abortions should be limited generally to those performed within 18 weeks from the last menstrual period. Prior to an abortion, the woman should be counseled on the options for management of an unwanted pregnancy. She should be allowed sufficient time for reflection prior to making an informed decision. If counseling has been provided elsewhere, the physician who is to perform the abortion should verify that the counseling has taken place.

In addition to the history, physical examination, and indicated laboratory procedures, an Rh factor and antibody screen should be performed. Every unsensitized Rho(D) negative woman who has an abortion should receive Rh immune globulin. Before the patient's release from the facility, aspirated tissue should be examined to ensure that villi or fetal parts are present. If villi or fetal parts are not identified with certainty, the tissue specimen should be sent for further pathologic examination and the patient alerted to the possibility of an ectopic pregnancy.

The patient should receive instruction in the use of family planning methods, and counseled that abortion is not recommended as a primary method of contraception.

ADMINISTRATION OF PHYSICIAN'S OFFICE AND OUTPATIENT CLINIC

MEDICAL RECORDS

Physicians' offices and outpatient clinics should maintain accurate medical records for each patient. The record should be legible, concise, cogent, and complete. In addition, the record should allow easy assessment of the care provided to determine if the patient's health needs have been effectively managed. Because medical practice frequently involves several physicians and other professionals and because the record serves as a vehicle for communication among all members of the health care team, it should be readily accessible.

All medical information should be confidential and the record secure. All records should be retained for the

period of time prescribed by law and by good medical practice.

At the initial visit, a comprehensive data base and plan of therapy should be established and updated during each visit. Correspondence, operative notes, and laboratory data should be reviewed and filed chronologically in the patient's medical record. Any pertinent date regarding changes in health status or inpatient care should be recorded; this may take the form of a diagnostic summary.

QUALITY ASSURANCE

Personnel in each outpatient clinic and physician's office should assess the effectiveness and efficiency of health care management. In the outpatient clinic, evaluation of patient care should include assessments of the completeness of medical records, the accuracy of diagnoses, appropriate use of laboratory and other services, and outcome of care. It should include the identification of potential problems in the care of patients, the objective assessment of the cause of problems and designation of mechanisms to eliminate them. Efficient use of medical resources can be documented by evaluating use of personnel, finances, equipment, and facilities.

Gynecologists should periodically review their office practices, comparing it with standards of patient care and office practices suggested by the scientific literature and continuing medical education programs.

PERSONNEL

Administrative and professional personnel requirements in physicians' offices and outpatient clinics depend on the patient load, pattern of practice, and type of facility. The members of the health care team should participate in the specific areas of care according to their training and within written definitions of their responsibilities. Policies and responsibilities should be reviewed and revised periodically. Regular meetings of personnel should be encouraged,

and there should be an ongoing program for in-service training.

FACILITIES AND EQUIPMENT

The physical facilities and equipment required depend on the type of practice and patient volume, but certain items should be reasonably available for the care of patients within the office or clinic setting. For example, the reception area should have comfortable seating, patient education materials, and conveniently located rest room facilities. Sufficient space should be provided to ensure that medical and financial records are handled and stored with security and confidentiality.

A comfortable and private area should be provided for interviews and for counseling with the patient or her family. The physician's office may serve as a consultation room. Separate rooms, other than the physician's office, should be available for use by nurses, social workers, health educators, and other members of the health care team. Equipment for each consultation room should include at least a desk or table with two chairs.

The following equipment should be accessible to, although not necessarily in, each examining room:

- Biopsy instruments
- Instruments for vaginal and rectal examinations
- Microscope
- Sphygmomanometer
- Stethoscope
- Reflex hammer
- Ophthalmoscope
- Scale
- Supplies for obtaining
  - Specimens and cultures
  - Wet slide preparation and bacterial smears
  - Cytologic studies
- Equipment necessary for diagnostic studies and operative procedures performed in the facility

When local anesthesia is used, the following equipment should be available for emergency resuscitation:

- Positive pressure device and a source of oxygen
- Intravenous equipment and fluids
- Suction
- Laryngoscope with assorted airways

The exact number of examining rooms required depends on the patient load and type of practice; however, even a solo physician's office should have at least two examination rooms. The following equipment should be available in each examining room:

- Screening to permit patient privacy
- Handwashing facilities and paper towels
- Examination table with suitable disposable cover and a stool
- Examination light
- Gynecologic examination equipment and supplies
- Work counter or table
- Small desk, table, or shelf for writing
- Storage cabinet

The utility room area should contain the following facilities:

- Work counter
- Handwashing facilities and paper towels
- Sink
- Cabinets for storage
- Locked medicine cabinets
- Refrigerator
- Facilities for sterilization unless central sterilization is available
- Waste receptacle

For larger practices or clinics, a conference and patient education room may contain the following items:

- Comfortable chairs
- Conference table
- Educational materials and pamphlets
- Chalkboard

- Bulletin board
- Models and demonstrating equipment
- Screen
- Slide projector
- Movie projector
- Video equipment

Specific plans and procedures for the health and safety of patients and personnel should include the following information:

- Methods for controlling electrical hazards and preventing explosion and fire
- Procedures for controlling and disposing of needles, syringes, glass, knife blades, and contaminated waste supplies
- Methods for storing, preparing, and administering drugs, when applicable
- Plans for handling reasonably foreseeable emergencies, including methods for transferring a patient to a nearby hospital
- Plans for emergency patient evacuation and the proper use of safety, emergency, and fire equipment
- Plans for training of personnel in cardiopulmonary resuscitation
- Plans for adequately maintaining and cleaning the facilities

ADMINISTRATION OF FREE-STANDING AND HOSPITAL-BASED AMBULATORY SURGICAL FACILITIES

MEDICAL RECORDS

All ambulatory facilities should maintain an accurate and efficient record system. The records used should conform to a standard record used in the community or back-up hospital. All medical information should be secure, confidential, and readily accessible. The record should be legible, concise, cogent, and complete. Furthermore, the record should facilitate assessment of the care provided to determine if the patient's health needs have been iden-

tified, diagnosed, and managed effectively. The patient's record should include details in regard to any anesthetic used, the procedure performed, any difficulties encountered, and the patient's subsequent condition. Because modern medical practice frequently involves several physicians and professionals, the record should serve as a vehicle for communication among all members of the health care team.

This record should contain sufficient information not only to justify the preoperative diagnosis and the operative procedure, but also to document the postoperative course. The record should contain the following information:

- Patient identification data
- History and physical examination findings
- Provisional diagnosis
- Diagnostic and therapeutic orders
- Surgeons' and nurses' notes
- Laboratory results
- Operative consent
- Operative report
- Anesthesia report
- Tissue report
- Medications record
- Discharge note and instructions

The record should be completed promptly and signed by the attending physician. A discharge note should be written or dictated.

The ambulatory care facility should keep registries of admissions and discharges, operations, and controlled substances. Records should be kept confidential and should be protected against fire, theft, and other damage for the duration of time prescribed by law and by good medical practice.

QUALITY ASSURANCE

The effectiveness of patient care and the use of the ambulatory surgical facility should be continually evaluated. A team of professionals qualified to assess all aspects of

patient care, including completeness of medical records, accuracy of diagnoses, and outcome of care, should be responsible for evaluating patient care. The evaluation should include identification of potential problems in the care of patients, objective assessment of their cause, and designation of mechanisms to eliminate them. Particular care should be taken to identify ambulatory treatments that might have been undertaken more appropriately on an inpatient basis.

PERSONNEL

The efficient operation of an ambulatory surgical facility requires that administrative and professional personnel be assigned on the basis of the number of patients, patients profiles, types of procedures performed and facility design. Written policies descrioing the specific responsibilities of each member of the team are desirable and should be reviewed and revised periodically. There should be an ongoing program for in-service training of personnel.

The governing body of the ambulatory surgical facility has the final authority and responsibility for the appointment of the medical staff. Privileges should be granted only to those who are properly trained, have been licensed, and have demonstrated competence. These privileges should not exceed those granted to the same individual in at least one accredited hospital within the geographic area.

FACILITIES AND EQUIPMENT

The general physical design for a free-standing or hospital-based ambulatory surgical facility depends on the number and types of surgical procedures to be performed. The facility should provide a comfortable, safe environment with minimal architectural barriers. Traffic flow should be convenient and efficient. A multilevel facility should have elevators that can accommodate stretchers.

The facility should include space adequate for the following functions:

- Reception and waiting
- Administrative activities, such as patient admission, record storage, and business affairs
- Patient dressing and lockers
- Preoperative evaluation, including physical examination, laboratory testing, and preparation for anesthesia
- Performance of surgical procedures
- Preparation and sterilization of instruments
- Storage of equipment, drugs, and fluids
- Postanesthetic recovery
- Staff activities
- Janitorial and utility support

The instruments, equipment, and supplies used in the ambulatory surgical facility should be equivalent to those used for similar procedures in an accredited hospital and should provide for the following:

- Control of sources and transmission of infection
- Infection surveillance
- Functional oxygen and suction
- Resuscitation and defibrillation
- Emergency lighting
- Sterilization
- Emergency intercommunication

Specific plans and procedures should be established for the health and safety of patients and personnel. Such plans and procedures should include the following information:

- Methods of control against the hazards of electrical or mechanical failure, explosion, and fire
- Comprehensive emergency plans, including but not limited to patient evacuation and the proper use of safety, emergency, and fire extinguishing equipment
- Equipment and personnel for handling reasonably foreseeable medical emergencies arising from services rendered
- Provision for transferring unanticipated emergency cases to a nearby backup hospital

- Training of personnel in cardiopulmonary resuscitation
- Control and disposition of needles, syringes, glass, knife blades, and contaminated material
- Proper storage, preparation, and administration of drugs
- Facilities that are accessible, barrier-free, and safe for all, including the handicapped
- Adequately maintained and clean facilities

PLAINTIFFS' OPENING STATEMENT BY MS. CONNELL

[20][1] * * * Through these three acts the State of Illinois has singled out for differential treatment the abortion procedure and, as a consequence of that singling out, requires a physician who performs first and early second trimester abortions to construct a small hospital for the performance of what is essentially an out-patient procedure.

Plaintiffs challenge the statutes and their accompanying regulations, your Honor, as a violation of the Supreme Court's decision in Roe vs. Wade and the decisions following the Roe decision, most notably the 1983 decision of City of Akron vs. Akron Center for Reproductive Health.

These cases, in plaintiff's view, stand for the simple proposition that during the first trimester and early second trimester pregnancy a woman's decision to terminate her pregnancy and the effectuation of that decision must be left to the woman and her attending physician, free from state interference.

As a consequence, plaintiffs contend that these three acts and the regulations that are enacted pursuant to them, as a whole, may not constitutionally be applied to physicians who perform first and early second trimester abortions.

* * * * *

[1] Numbers in brackets refer to the Court Reporter's original pagination of the Transcript of Proceedings.

EXCERPTS FROM TRIAL TRANSCRIPTS

[376][1] THE COURT: So, you would be ready, in effect, to put the whole deposition in?

MS. KREISEL: Just about. If I have to bring him in I am sure that I will ask him a couple other questions. But I don't think that I will cover much else that isn't in there, if anything. I was prepared to do that.

THE COURT: All right. I don't know why there would be any objection to letting that come in as evidence. You do have the right of cross-examination. In that way you can clarify anything that you wish.

MR. GILBERT: Well, we object and we don't think that it is—well, you know, we object. But if that's your Honor's ruling we will abide by it, of course.

THE COURT: Well, I do think that, for purposes of a preliminary injunction hearing, that it will be valid because it will avoid the legitimate objection that you have that you weren't prepared—that you weren't taking this as an evidentiary deposition and, therefore, had not asked, perhaps, some of the questions that you would have otherwise asked.

MR. GILBERT: Yes. All right.

The other problem that I have is that we just got the transcript yesterday afternoon and I haven't had a chance to fully review the transcript prior to having it brought before the Court. But, given that we want him—I would [377] like to see him testify and anything that can speed this up and get it over with, we would agree to, I mean, we would go ahead with.

[1] Numbers in brackets refer to the Court Reporter's original pagination of the Transcript of Proceedings.

THE COURT: All right. We can bring him in this afternoon then?

MS. KREISEL: I will call his office right now.

THE COURT: All right. Because usually Wednesday afternoons are not, historically, the best time.

MS. KREISEL: He is a sort of a special person.

THE COURT: Right, but if he is not conducting surgery—that I wouldn't interfere with. But I would expect him to be present otherwise.

MS. KREISEL: I understand, Judge.

THE COURT: And the sooner he gets here the quicker he will be free to leave.

We will put him right on; you can assure him that we will put him right on the minute that he arrives.

So, on that basis, then, we will set it for 2:00 o'clock. We will recess as soon as you have completed the direct of Dr. Ragsdale.

MR. GILBERT: Fine.

THE COURT: And then we will have his cross after the other expert has testified. After that testimony has been taken.

* * * * *

[531] * * * MR. GILBERT: Okay. The other persons, Mr. Passeri, someone—one or two people from the Department of Registration and Education and this other unknown person from the Department of Public Health we have never been informed of before and we would like an opportunity to depose them, or, in the alternative, in the interest of getting this over with, getting it done, perhaps we could hear their direct and if we feel that there is a need to depose, do it before performing a cross.

THE COURT: Well, what I will do, though, I will give you a few minutes to interview each of these witnesses but we are not going to have time for full-scale depositions of all of these people.

I am treating this as an emergency matter, otherwise, I've got trials scheduled from now on through the end of the year and I just—I think that, from what has been indicated, the testimony, I mean, I understand that it is important that we complete this testimony and rule.

Now, we are not trying this case as a final trial, this is a preliminary injunction hearing.

* * * * *

[622] THE COURT: Well, I am planning to rule at the conclusion of this proceeding.

If I permit, after filing of memos and further exhibits, or anything else, I am going to warn you, I have got some very major opinions that I still haven't had time to write that have been waiting for months to be issued, and I keep getting hit with emergencies all the time and so—I have taken this to be an emergency proceeding; I didn't send it to a magistrate because of the problem that the magistrates have at this time.

So, any arguments that are going to be made or that should be made, I am going to require that they be made as we go through this because this is only a preliminary—well, not "only," but it is a preliminary injunction hearing and not a final injunction and I think that it is most important that this proceeding be concluded as soon as it can be, with the right of everybody, of course, to present what evidence they feel is relevant.

Then I have got to decide if the Court is going to be of any help with respect to the alleged emergency here, otherwise, I mean, I have got people who have been waiting for several months who thought that I was going to be ruling two months ago and I have never been able to get back to the matter.

MS. CONNELL: We appreciate that, Your Honor.

POST-TRIAL PROCEEDINGS

[861][1] * * * THE COURT: All right. Is there anything else now that you would suggest?

MR. GILBERT: One other matter, and this doesn't relate directly to this order, and that is, just in terms of the future course of this proceeding, given the scope of the evidentiary hearing and the briefing that has gone on and the scope of your Honor's order, it seems to us that there probably isn't a need to have another trial in this matter and that we have pretty much aired the issues here and relatively completely [862] and, to that end, we have made a suggestion to the state, a request, that we would be willing to turn this into a final injunction order pursuant to Rule 65, which allows a proceeding for preliminary injunction to be a proceeding for a final and permanent injunction as well.

THE COURT: Right. A permanent injunction.

MR. GILBERT: Yes. Right.

Now, obviously, there are risks for both sides if one were to do that because if there is an appeal we will have a final order; we wouldn't have an opportunity to come back with a supplement—

THE COURT: To supplement the record.

MR. GILBERT: To supplement the record, yes. And, of course, the state has that same risk.

THE COURT: Right.

MR. GILBERT: But we thought, in the interest of judicial economy and the economy of the parties, that that might be the way to proceed. We have made that suggestion to the state and Mr. Flahaven told me yesterday that, at least as of yesterday, he wasn't willing to accede to it, but I don't know what his position will be on that.

[1] Numbers in brackets refer to the Court Reporter's original pagination of the Transcript of Proceedings.

THE COURT: You haven't had a chance yet to decide what the state's position would be?

MR. FLAHAVEN: I would imagine that until the time to appeal your Honor's original order passes, that this—[863] I should keep that option open for my client. If they elect not to appeal we can always come in and make this a permanent injunction. If they elect to appeal the preliminary, well, then, that will answer the question.

THE COURT: Right. You have to think in terms of what kind of a decision the Seventh Circuit would be able to render. In the one case it is a sort of a balancing and a likelihood type of consideration, whereas, the other is a final decision.

It could conceivably be that the preliminary injunction could be upheld where a permanent would not. I mean, I am not suggesting that I think that that is the way that it would go but, in theory, it might be.

On the other hand, both sides would probably get some discussion as to the Seventh Circuit's view of the case for the purpose of supplementing the record.

But, of course, on the other hand, if the Seventh Circuit felt that the record was inadequate they could always remand it anyway.

I really do think, though, that both sides did an excellent job in putting in their respective cases. I guess that we would really look to the state to see whether they felt that they had any other evidence that they had not introduced that they would want to have put in.

I guess that the third alternative would be, if both [864] sides wanted to supplement the record somewhat further by written supplementation, I could review all of that and see if it would change my position; if not, it could go up

then with the supplementation in the record. I mean, that would be another way as to economy for both the clients as well as the Court.

But, on the other hand, that would be giving, maybe, a more complete record—if, in fact, there is anything else that anybody thinks should be included.

MR. GILBERT: Well, I think that that sounds like a good idea that we would be agreeable to. But that, obviously, being subject to the right—

THE COURT: Maybe supplemented by evidentiary affidavits, in effect.

MR. GILBERT: Obviously, subject to the right to object to any evidentiary affidavits and the right to rebut on both sides.

THE COURT: Right. Yes.

MR. GILBERT: But I think that the notion of sending this thing up, if it is going to go up, as a final order would really save everyone an awful lot of time because the preliminary injunction—

THE COURT: But I think that, really—

MR. GILBERT: —is going to come back down one way or another.

THE COURT: Yes. Right.

[865] I can't really think of anything more that either side would put in that would really make all that much difference in the Seventh Circuit's decision on the case. It is really—the guts of the arguments on both sides are in and the evidence is in. It is really a question of interpreting the Supreme Court decisions and maybe drawing a few reasonable inferences. But there really isn't all that much in the way of factual disputes, it is really more a question of interpretation of the existing laws.

MR. GILBERT: Yes. Right. That's how we see it.

And to the extent that the state needs some time to maybe just determine whether there is anything that they

need to supplement, we would be willing, to the extent that we can do it under the rules, agree to an extension of time for their appeal for—you know, give them another 15 days or 30 days, or something like that. And, you know, if the state wanted, you know, maybe another 30 days to provide supplemental affidavits or not--but, you know, I don't want the appeal deadline to kind of force us into a situation where we have to have an appeal of this.

THE COURT: Right. Well, partly—I mean, I know that the state has various considerations on the matter.

MR. FLAHAVEN: Right.

* * * * *

TRIAL TESTIMONY OF RICHARD M. RAGSDALE, M.D.

Direct Examination

[52][1] * * * BY THE WITNESS: A The first thing that happens to a patient when she arrives for an abortion procedure is that she is given appropriate chart forms, and so on, to fill out, a medical history, the demographic data and certain statistical data which we obtain for our own purposes.

The Exhibit No. 3 is a picture of a counseling, or what we refer to as a "counseling room" within our facility.

This might be termed an "interview room" by some; it is simply a private area where the individual patient, such other people as she may wish, and one of our counselors are able to sit and talk about the abortion decision, the abortion procedure; both the medical, the social aspects of the procedure, and where generally at this time, upon the completion of this discussion, if the patient continues her request for an abortion, a consent for the procedure is signed at that time.

Upon completion of these two steps—and Exhibit 4 is simply taken from the entryway to Procedure Room No. 2 at the Northern Illinois Women's Center.

* * * * *

[62] * * * Q What type of contact—
A I will qualify that remark by noting that during the initial examination, during the part that we refer to as the bimanual examination, the physician is in contact with the vagina but in general terms, no.

[1] Numbers in brackets refer to the Court Reporter's original pagination of the Transcript of Proceedings.

Q Are there any incisions made during a first trimester or early second trimester abortion?
A No, there are not.
Q Is there any stitching that is done?
A No, there is not.
Q All right. Thank you, Doctor. Let me take the model away here.
A All right.
Q And will you please explain to the Court what physical requirements are necessary from a medical point of view for a safe first or early second trimester abortion.
A Sure. The physical requirements for a safe first or early second trimester abortion are illustrated in exhibits, and you have earlier marked these, 4 through—well, through whatever the last number is here. I am a little confused as to the numerical order but they are demonstrated by the exhibits that we have presented here.

Would you like me to renumerate?
Q Yes. If you would.
[63] Would you please list them.
A Okay. The first requirement is a room of adequate size to contain the necessary equipment, to contain the patient, to allow room for the physician and to allow room for a nurse assistant.
Q When you went through that process or procedure before, and I don't know if you mentioned a nursing assistant, but do you normally have a nursing assistant with you when you perform an abortion?
A Yes, I do.
Q All right. Please continue as to what requirements are necessary.
A Okay.
Q From a medical point of view.
A Yes. Referring again to Exhibit 4, we can see from the entry to the room that we have a standard gyne-

cologic examining table, we have a small, in this case, three layer table to contain instruments and whatever additional equipment or items are necessary, you know, and in this case we have some Kleenix and, actually, on the second shelf there there is some Pap Smear fixing solution but, basically, we need a small table for instruments.

We need a suction machine, which, again, in this photograph in Exhibit 4 can be seen in the upper left.

It is certainly nice to have a waste receptacle in [64] the room and we have a sanitary waste receptacle, a self-closing wastebasket, that you can see there.

A stool for the physician to sit on, which, again, is illustrated by these procedures.

Adequate space for emergency medications which in this particular procedure room, are contained in the drawer of the suction machine.

There is an additional requirement, which, in this case, is contained within the room, and that is a place for the patient to disrobe, a privacy area for the patient to disrobe. And in this case that is actually contained within the room rather than separately.

There is one requirement that is not illustrated here and that is that the physician must have some place to wash his or her hands. It need not be in the procedure room but it should be convenient to the procedure room. It could be in the procedure room but it need not be, but there needs to be a place to wash hands.

Q Apart from those physical requirements that you just mentioned, is there anything else that you, in your professional opinion, based upon your experience in performing abortions, consider necessary from a medical point of view for the performance of safe first trimester or early second trimester abortions?

A Does your question include such things as laboratory [65] tests or medications or support or is this just physical?

Q Well, let's just talk about the physical requirements of the examining room.

A Everything that is—

Q I mean, the procedure room.

A Yes. Everything that is medically required is right here.

Q Now, do you have an opinion as to what is the most appropriate setting in which first trimester and early second trimester abortions should be performed?

A Yes, I do.

Q What is that? What is your opinion on that?

A The most appropriate setting is an environment as closely similar to a physician's office as can possibly be obtained, with the equipment that I have specified and indicated here.

Q And why do you say that?

A The first reason, and this is based upon my own personal experience performing abortions in and out of hospitals, is that everything that is necessary can be contained within a physician's office or similar type environment.

Secondly, the environment to be found here from an emotional standpoint—and it is important to remember that in terms of abortion patients emotion is as important as the technical medical aspects and that the emotional support that can be offered in this environment is much greater than can be [66] offered in the very cold and austere operating room type environment.

Third, it is certainly much easier to assure privacy in any type of out-patient and any type of office environment.

And, fourth, interestingly enough, with something like this which contains only the necessities you are not tempted to do extras, you do what is at hand and you don't do

extra things that you might be tempted to do, you know, if it was there.

Q Would you consider—or is a first trimester or second, that is, an early second trimester abortion, is that a major surgical procedure or is it a minor procedure, or how would you characterize it as a physician?

A It is a minor procedure. Whether it is characterized as a "surgical procedure" or as a "procedure-procedure," that depends upon whose classification of diseases and procedures you are referring to, but it is a minor procedure.

Q How long does the actual abortion procedure, the portion where the physician is involved in the vacuum aspiration and curettage, to the extent that there is any, how long does that take?

A Well, if you are—

Q I mean, apart from the counseling and the prior examination of the patient and the lab tests, if any, and such [67] things as that.

A Yes. All right. As you recall, there were two parts; one was the physician exam and then the anesthetic injection and then there was the procedure itself.

Q Yes.

A The combination of the two takes approximately eight minutes.

Q And that includes the time that you must wait for the anesthetic to take effect?

A No. Then you should add three minutes for the patient to wait.

The patient time will be approximately ten to twelve minutes.

Q Now, have you kept any records or do you have a sense of what kind of complications—what the rate of complication is for the first trimester and early second trimester abortions that you have performed?

A Yes, I have.

Q And will you tell the Court what that complication rate is.

Can you answer that question or would you like to break it down a little?

A As asked, the question is a little difficult.

Q Okay. Well, let me try to break it down for you then: You mentioned before that you have performed over 40,000 [68] abortions?

A Yes.

Q What is the rate of major complications, and by that I would define it as being complications requiring some type of hospitalization, in the first trimester and early second trimester abortions that you have performed.

A Those patients who have required immediate hospitalization, which I will define as movant from our office to the hospital, we have had nine patients.

Q Nine out of 40,000?

A That is correct.

Q Now, you being a physician and board certified, would you consider that to be a low or high complication rate?

A Well, "low" and "high" are relative and generic terms depending upon interpretation.

I can only say that I personally believe that that is low.

Q Have any deaths occurred as a result of any abortions—

A No.

Q —which you have performed?

A No.

Q What is—

A I will qualify—

Q Excuse me. Go ahead.

A I qualified my answer there by saying "immediately after [69] the procedure," or would so qualify.

Abortion complications divide into two categories, those that occur right now and those that occur two or three or four days later. Okay?

Q Well, what is the rate of complications that occur two or three or four days later? Do you have that figure?
A Okay. We have had, with major complications, probably another 15 patients, 10 to 15 patients, who have been admitted, and by "major" I am defining this as any patient with a fever that lasts longer than 48 hours, any patient requiring hospitalization for a fever, any patient with an abscess, any patient with, I mean, you know, these are basically what we are talking about.
Q So, let me see if I am adding this up right.

We are talking about 19 to 20, 25 major complications?
A I think that the group that I am talking about—
Q "Major complications," as you have defined that term?
A I think that of the group that I am talking about here, and in 1984 I presented this data at a meeting and I believe that we presented 24 patients at that time. 24 patients who fell into this category.
Q Are those complication figures roughly comparable with nationwide figures?

And I am referring to figures nationwide for abortions of the first trimester and early second trimester type.
[70] A They are either comparable or better than nationwide.
Q What about minor complications?

And maybe you can explain to the Court what you mean by "minor complications," if you have an opinion about that.
A All right. "Minor complications" we would define as something out of the ordinary, something that was in fact a medical problem but that did not require hospitalization, did not produce prolonged morbidity or this type of thing.

First of all, let me say that in terms of the major complications requiring hospital admission, okay, and I want to back up on that, at the risk of being narrative, and

indicate that none of those patients involved hemorrhage, okay?

The risk of hemorrhage during this procedure—we have not had an immediate blood transfusion in forty-some odd thousand cases. Okay.

Now, subsequent problems, involving things like fever, minor infection, this type of thing, and we have been able to indicate that our apparent complication rate in this regard has been 1.3 to 2 percent depending upon on how we analyze the data.
Q The type of complications that you are talking about there, the 1.3 to 2 percent, are any just slight fever or any slight complaint about any—
A Well, any fever that the patient contacts us for or [71] another physician where it is felt significant enough to place her on antibiotics, or otherwise treated.
Q I see.
A Now, there is a third group of medical complications here and that involves patients who, for whatever reason, may need a recurettage. This may be due to a retained portion of the pregnancy tissue, it may be due to completely missing the pregnancy during the abortion procedure or it may be due to our suspicion that one or the other of these or our concern about something like an ectopic pregnancy, leads us to do a curettage even though, as it turns out, one may not have been completely necessary. We estimate that this occurs approximately one in 300 patients. In one of 300 patients as to that.
Q Now, you mentioned the type of complications there and you mentioned hemorrhaging, which you have not seen but that is, I take it, a possible complication with regard to the first trimester or early second trimester abortion procedure?
A That is a possibility.

Q As to that type of abortion.
A Yes. That is a possibility.
Q Now, what other possible types of complications are there?
A The two big immediate problems or complications—
Q The biggest ones, I am referring to.
[72] A Yes. It would be hemorrhage, which we don't see, and uterine perforation, which we have seen.
Q And I take it that the 9 that you have mentioned may have been uterine perforations?
A They were uterine perforations, that is correct.
Q Are uterine perforations a complication of any other gynecological procedures that are performed in hospitals—excuse me, in physicians' offices?
A They occur with dilatation and curettage and they occur with the insertion of intrauterine devices.
A By "dilatation curettage" you are talking about the D&C that you were discussing previously?
A That is correct.

* * * * *

Q Do you have any knowledge about the comparable complication rates regarding insertions of IUD's and first trimester and early second trimester abortions?
A Yes, I do.
Q And can you tell us about that.
A Are we talking about nature of or—
Q Well, let's talk about uterine perforation.
[73] A Fine. All right.

That occurs in both procedures and there are varying incidences quoted but probably approximately the same incidences of maybe one in a thousand.
Q And for the dilation and curettage situation, do you know if there is any evidence regarding comparative complication rates—
A I do not know—

Q —between that procedure and the first trimester and early second trimester abortions?
A I do not know of any data that have attempted to compare the two.
Q Now, have you discussed the major complications that might arise from a first trimester or early second trimester abortion? Have you given us a picture of that?
A Yes, I believe I have.
Q Now, are any of those complications less likely to occur if the first trimester or early second trimester abortion procedure is performed in an operating room rather than in a physician's office?
A No, they are not.
Q Do you have any basis for—is that your professional opinion, first of all?
A Yes, it is.
Q And what is the basis for your professional opinion?
[74] A The basis is two-fold: First has been my own personal experience and, secondly, my personal experience together with others' has contributed to a vast nationwide data base collected by the United States government's Center for Disease Control through the joint program for the study of abortion, which has accumulated data from all 48 states, from every reporting agency or group that they could and has been doing this for 15 years since 1970 and this study has clearly demonstrated that out-patient abortions, wherever performed, is as safe and probably safer than an abortion performed in a hospital.

And this is, again, as I say, consistent with the experience of those of us who have been providing the services.
Q Do you share notes with others who have performed a substantial number of abortions?
A Yes, I do.
Q Is there some kind of an organization of which you are a member where you do that?

A Yes. The organization is the National Abortion Federation.
Q Is one of the bases for your opinion what you have learned through meetings of the National Abortion Federation and contacts with other members?
A Yes, it is.
[75] Q And who are some of—well, generally, who are members of the National Abortion Federation?
A The National Abortion Federation is composed, again, of a group, nationwide, of providers of abortion services.

Now, these range from individual physicians who perform abortions in their offices through Planned Parenthood affiliates, clinics similar to mine or some that are, in other states, not regulated; it provides hospital providers—so, it covers both teaching and non-teaching and it covers the spectrum of abortion providers nationwide and provides a high percentage of the abortions that are totally done nationwide.
Q Now, in your professional opinion, based upon your experience and your knowledge of the field, and through reading in the field—and I take it that you do read the literature on the abortion practice—
A Yes.
Q And through the National Abortion Federation and other sources—
A Yes.
Q —what are the factors that primarily affect the safety of first trimester and early second trimester abortion procedures?
A The basic factors are three: One is the skill, experience and professional integrity of the physician performing the abortion.
[76] The second is the duration of the pregnancy and the third relates to the techniques that may be used in doing the abortion procedure itself.

Q Okay. I think we understand what you mean by the "skill and integrity of the physician," and the second factor that you mentioned was the duration of the pregnancy. Can you explain to the Court what you mean about how the duration of the pregnancy affects the safety of the procedure.
A This is a clearly demonstrated fact, that starting from five weeks' pregnancy and going through 12 weeks' pregnancy there is a slow but linear increase in the rate of death and probably of major complications associated with abortion and that from 14 weeks' pregnancy onward this increasing rate of complications continues and at a slightly accelerated rate.

This leads to the fact that in, for example, the situation—well, I will stop there.
Q Are there studies that have been conducted that demonstrate what you just testified?
A Yes. This is one of the clearest demonstrations from the Joint Program for the Study of Abortion of the Centers of Disease Control.
Q The third factor that you mentioned in addition to the skill and integrity of the physician and the duration of the pregnancy was the type of procedure used.
A Yes.
[77] Q Could you elaborate a little bit on that.
A The common procedure used now for first trimester abortion is the suction curettage. We didn't always know about this procedure. The traditional dilatation and curettage used to be used a number of years ago for this. It took a while for this procedure to disappear—and some people still do this. It is a more—it carries a higher morbidity rate. So, it is important to do the right procedure, which is a suction curettage.

There are various methods—well, okay. Let me back up. The second biggest factor in the procedure that we see

customarily nationwide that influences morbidity and mortality is the type of anesthesia that is employed.

Now, general anesthesia is distinctly more hazardous, both in and of itself because of the general anesthetic and also as a risk of problems or complications to the abortion than is local anesthesia. This is why we prefer to use local anesthesia.

Q Overall, Doctor, do you consider a first trimester or early second trimester abortion to be a risky procedure?

A No, it is not.

THE WITNESS: May I draw two comparisons for your Honor?

THE COURT: Yes, you may.

BY MR. GILBERT: [78] Q Yes. Go ahead.

A Every time a woman goes to her drugstore and gets a package of birth control pills, okay, the government includes within this a little package insert and as a part of this there is a paragraph that demonstrates the risk of mortality, okay, from the conceptive method during any given 12-month period of time. Okay.

We are now at a point where the woman who uses abortion and nothing else is medically as safe as the woman who takes birth control pills or uses an IUD. Okay. It is incredibly safe. Now, that's a statistically valid and, you know, this would pass muster with somebody like Christopher Tietz as a statistically valid statement.

To relate it more to everyday affairs, the woman who has an abortion probably takes a greater risk during her automobile trip to and from the clinic than she does during the procedure itself.

* * * * *

[80] * * * Q Now, in your opinion, given your familiarity with those acts, do you consider them to be, the requirements of those acts—and I am talking in terms of

the Medical Practice Act, only the requirement that abortions be performed in an Ambulatory Surgical Treatment Center or a hospital and not the licensing requirement for physicians but the Medical Practice Act as it applies to abortions, the Ambulatory Surgical Treatment Center Act and regulations and the Health Facilities Planning Act as it requires Certificates of Need to be obtained by Ambulatory Surgical Treatment Centers; do you consider those acts to be, in your professional opinion, to be medically—the requirements of those acts to be medically necessary for the performance of safe first and early second trimester abortions?

A No.

Q Why do you say that?

A There is nothing inherent in an abortion procedure to separate it from any other medical procedure that a physician appropriately licensed and of integrity and good conscience would undertake in his office or in whatever environment he might deem appropriate for himself, okay, and there is no need—

Q Well, let me ask you—

A —medical necessity for the rest of this.

* * * * *

[82] * * * Q Do you know whether or not your facility presently complies with all of the requirements of that act that is in front of you, or with those requlations, that act and those regulations that are in front of you?

A Do I know?

Q Do you know?

A Yes, I know.

Q Well, what do you know as to whether or not it does comply?

A Our facility, or my facility, contains substantial variances from the physical plant requirements that are currently promulgated under these regulations.

* * * * *

[86] Q Why don't you know?
A Because that requirement is an architectural description that can be used to encompass matters related from fire safety to the presence or absence within or without the facility of toilets or public facilities and, depending upon the discussion that you have, it could mean a variety of things and I don't know if we are in compliance with that or not.
Q Now, by way of example, you've gone through a few of the provisions and are there other provisions of which you are aware that the Northern Illinois Women's Center is either not in compliance with or you are not sure whether or not it is in compliance because you can't tell?
A That is correct.
Q Now, what would be necessary, in general terms, for you to be in compliance? What kind of a facility would you need?
A Well, these regulations very clearly describe, okay, and are excellently drawn for taking a hospital operating environment, moving it into an out-patient environment somewhere, taking away the beds and calling it an ambulatory surgical treatment center, and that's exactly what is described in these regulations, is a hospital operating room environment without beds.
Q Do you think that a hospital operating room environment is necessary for the safe performance of first and early second trimester abortions?
[87] * * * THE COURT: I would ask that you go further with some witness, whether it should be the plaintiff or an expert, beyond the mere question "necessary".

I think the question of whether it is desirable or whether there is some percentage increase of safety or other gradations might be considered other than bare—the bare word "necessary". I mean, because I am not sure from all of the cases what, perhaps, may be the exact language of the test that might be required, that the Court might be required to use.

MR. GILBERT: All right. Well, we think that the burden is really on the state—

THE COURT: I could conceive in some cases it might be said that while it is not necessary it might enhance safety or be desirable but in other cases he might testify that it wouldn't have any effect at all on medical safety or the protection of the mothers.

MR. GILBERT: Well, your Honor, as we read the cases—

THE COURT: If your position is going to be that the minimal level of necessity is the criteria that's one thing but you may want to go further so far as your testimony is concerned, or maybe that will do that on cross-examination.

* * * * *

[110] * * * Q Well, I am not asking you to cost-account it but does it cost you anything?
A Yes, it does.
Q And, apart from that kind of time cost that you have discussed, is there any actual out-of-pocket cost or costs, additional expenses that you have to incur that you would not normally incur to comply with these regulations?
A Yes.
Q Can you tell the Court about them?
A All right. The regulations 205.130, .1320, .1350, 60—that is, 1360, 1370, 1390, 1380, .1400 and .1410—
Q And that was all Subparagraph or Subpart (i) of these ASTC reg's, is that right?
A That was all Subpart (i).

Q Is that all that you have referred to?
A Yes.

* * * * *

[112] Q Now, Dr. Ragsdale, I am going to go into the various particular provisions that you consider burdensome but before that can you tell the Court generally as a kind of an overview before we go into the particulars what it is that concerns you about these provisions, why you consider them to be medically unnecessary for your practice and for physicians' offices in which first trimester and early second trimester abortions are performed.

If you will give an overview, then we can go into the paticulars, because I think that it will help the Judge in understanding your testimony.
A Okay. Could you repeat that question so that I know exactly what it is that I am trying to answer.
Q I want you to tell the Judge generally what it is about this, about the provisions of this act, what characteristics these provisions have that, in your mind, make them medically unnecessary.
A All right. In broad overview, they attempt to tell or dictate the exact construction of a medical office without any real, how do I say it? Without any real relationship to the particular circumstances of the individual who is doing this and, you know, some of them—some of them are appropriate, some of them are always necessary, some of them are never necessary but, basically, they are attempting to tell you either to do the obvious or to dictate to you what you must [113] have, regardless of your circumstances.
Q Okay. Now, are you speaking only of the physical plant regulations in the ASTC reg's or are you speaking of all of the regulations?
A All right. Right now we were talking about the physical plant regulations, okay? What I just described is a

characteristic of the regulations in general but my answer was directed, at this point, to the physical plant regulations.
Q Well, let's talk about them generally because I think that Judge Nordberg wants to hear about your views on the regulations generally and doesn't want to have you just confine yourself to the physical plant regulations.

So, generally, what is it about these reg's that you have trouble with?
A Okay. Taken as a whole, as I say, some of them regulate the obvious or state the obvious and state it as a regulation.
Q Now, do you find any of them to be inappropriate?
A All right. Some of them can be, in certain circumstances, actually medically inappropriate and although—okay. And I would cite as an example some regulations under the subsection which is specifically applicable to abortion; that is, where the act singles out abortion and says you must do this in an abortion case, obstetric and gynecologic procedures.

And if we turn to 205.730 under "General Patient Care," and examine Section B under "Counseling," you will find [114] under B, Subparagraph 3, that a statement: "Counseling shall include a discussion of alternatives, description of the procedure, explanation of risks and possible complications."

Now, this sounds innocuous, okay, and no proper physician would not explain risks, would not explain procedures and would not engage in appropriate discussion. But this says that the counseling shall include discussion of alternatives.

Now, that may be appropriate in one case but let's take an example of a woman referred to me by her own gynecologist who has been told whether she wants it or not she must have an abortion or she will die. Now, this

woman certainly doesn't need a discussion of the alternatives or alternative of having a baby and placing it for adoption. This could be an extremely emotionally devastating thing to get into and yet the regulation says I must do it.

Now, that's an example.

Q All right. That's one example.

A Yes.

* * * * *

[120] * * * Q Is that subpart (b)(7)?

A Yes, (b)(7)—

Q Of Section 205.120?

A Yes, (b)(7). That's (b)(7) of that.

Q Does that mean that you must in your application disclose that information to the state?

A That is correct.

Q Is there any other portion of this particular that you find—

A Yes. There is (b)(9)(b) as to financial statements; that would be, then, (b), (c) and (d), if you will, which relate to the filing of attested financial statements.

Q Do you know if—

A And Subsection (f) under that, which is unique to abortion providers.

Q Let's talk about (b), (c) and (d), the financial statements.

As a private physician who is not performing [121] abortions, does he have to provide financial statements?

Did you when you were a private physician?

A No.

Q When you were a private physician who was not performing abortions?

A No.

Q Are you aware of anything in any kind of law, regulation, rule or private body that requires such statements to be disclosed?

A No.

Q You mentioned (f), Subpart (f).

A Yes.

Q We are here back at 205.120, Subpart (b), Subpart (9), Subpart, well I guess that is capital (F).

A That is right.

Q And that is the part that says that any corporation—"Any corporation operating an ambulatory surgical treatment center devoted primarily to providing facilities for abortion must have a physician who is licensed to practice medicine and all of its branches and is actively engaged in the practice of medicine at the center on the board of directors as a condition to licensure of the center."

Is that the provision that you had in mind?

A Yes.

Q You being familiar with these reg's, does that [122] requirement apply only to abortion facilities?

A It is stated there to apply only to facilities predominantly doing abortions, or whatever the words are that are used, but it is specific to abortion facilities.

Q And how does it burden abortion providers?

MS. KREISEL: Objection, your Honor. I think that the question is how it burdens Dr. Ragsdale; that's the issue in this case.

THE COURT: All right. I think that that's what he asked and then he broadened it to any abortion provider, and I do think that that is sufficiently relevant.

I will overrule the objection and permit him to answer, as to what the burden might be.

BY THE WITNESS: A At this time that particular provision does not specifically burden me.

Also under .120—

BY MR. GILBERT: Q Well, let's talk generally—you say "at this time," but how does that burden abortion providers, or could it burden abortion providers?
A It would be entirely possible for a corporation to operate an Ambulatory Surgical Treatment Center and not have a physician on its board of directors. This is not a requirement for any other Ambulatory Surgical Treatment Center. [123] So, if suddenly they wish to do abortions they would be required at that point to have a physician, an Illinois licensed physician, on their board of directors. It is fairly self-explanatory.
Q Okay. Well, I understand that, to you, some of these things are self-explanatory but I think that Judge Nordberg wants you to explain to him—
A Yes. All right.
Q —what it is, because you have been living under these requirements and regulations for some time and know them quite well.
THE COURT: You are talking not only to me but to the Court of Appeals as well.
MR. GILBERT: All right.
BY THE WITNESS: A I, of my own knowledge, specifically know of a facility in Illinois to which that particular requirement is a potential burden.
BY MR. GILBERT: Q For the reasons that you just stated?
A For the reasons that I just stated.
Q In that there was no physician on the board but they wished to perform abortions—
A That is correct.
Q —with licensed physicians performing them who were not [124] on the board?
A That is correct.
Subsection (c) under .120. Okay. That's relating to a new application for licensure, and I—the word "new" here is as defined by the department.

Q Is that defined in the regulations by the department, to your knowledge?
A They are about to define it under Subsection (c).
Q Oh, all right.
A Okay. That it is a new application for a change in ownership, change in location, remodeling of facility, so as to change interview, examination, surgical or recovery space, or to add services or programs.
Okay. At that point it becomes impossible; once you do one of these things you cannot simply renew your license and make one of these changes, you must get a new license, and if you moved your facility you must go through the whole procedure that got us here today.
Q Are there some additional requirements or is there any additional requirement that you must meet when you obtain a new license as opposed to just renewing an old license?
A Yes. If the new license relates to a change in location it requires a Certificate of Need.
THE COURT: Then I take it that the alternative is that for a regular physician conducting D and C procedures, [125] he is not required to do any of this?
THE WITNESS: That is correct.
THE COURT: Is that right?
THE WITNESS: Correct.
BY MR. GILBERT: Q One other thing—
A And finally—excuse me.
Q One other thing on the change.
A Yes.
Q You have been able—the department has renewed your license over the last several years even though your facility is not in compliance, that's your prior testimony, is that correct?
A Well, the words are yours; I'm not sure that I can—they have renewed my license for consecutive—

Q Well, all right. Just say it in your own words.
A All right. The department has renewed my license consecutively for the last 12 years. All right.

Such discrepancies or variances as may be present have not affected that renewal substantially.
Q Do you have any reason to believe that there may be different standards applied for a new license caused by a change in location or change in ownership as opposed to just a mere renewal of a license that has been in existence before?
A Yes.
[126] Q How do you know that?
A As a part of my efforts to begin the move process I had discussions on two occasions with members of the architectural staff of the Illinois Department of Public Health. The first of those meetings was on February 14th of 1985 at the department offices in Springfield.

I had a conversation initially with Mr. Jardine of their office and, subsequently, with Mr. Jardine and Mr. Linder.

The second of those two meetings was on March 4th of this year, again with the same two individuals present, plus Miss Holly of the Nursing Administrative or Supervisory Staff and Mr. Wilson of the Administrative Staff of the Department.

We discussed my need to move and the regulations as they would apply to a facility that I might subsequently create.

The department at that time indicated that some of their regulations could be—I want to choose my word carefully; variances could or might be allowed—this was discussion, nothing was formalized but that variances could be allowed from some of the standards set forth in the chapters that I have cited but that they would require considerably more substantial compliance than had been

the case in my previous facility and that they weren't going to [127] budge on too many of the factors or the requirements that they listed there.

I don't know if that was responsive to your question or not.
Q I think it was.

Is there anything else in 205.120 that you consider to be of a particular concern to you?
A Yes. The Section (e) again, which requires notification of the department any time, basically, any personnel in the facility change, and I don't even know of that requirement for a hospital, to notify the Department of Public Health if they change a staff physician. I mean, I think that that is unique. I could be wrong on that, but I, you know, just think—
Q All right. Do physicians who do not have Ambulatory Surgical Treatment Centers have to comply with—
A No, they do not.
Q —with those provisions?
A No.
Q All right. Let's turn to Section 205.230.
A Yes.
Q This is entitled "Standards of Professional Work."

Now, what, if anything, in that section do you consider to be medically unnecessary or inappropriate or obvious or otherwise burdensome that wouldn't be applied to you [128] if you were just a physician only?
A This is a regulation which is both medically unnecessary, in part, and burdensome, in part, and almost, if you will, vague or difficult of interpretation, in part.

The Consulting Committee specified under 205.230(a) and the subsequent subsections is unique to this particular environment, "A qualified physician will have consultants as a matter of course," and to spell out the nature of the

consultant function by regulation is, at the same time, belaboring the obvious and, yet, trying to specify a particular way to go about something that may not be appropriate in all cases.

Q Are you suggesting that a Consulting Committee of this sort may not be medically appropriate?

A That is true.

Subsection 5 under (a) indicates that the Consulting Committee shall act as a Tissue Committee and review, at least quarterly, pathologic reports from procedures performed by each physician and that they shall be recorded in the minutes.

The appropriate time to review pathology reports is when they are generated. If it is done then it is done and it needn't be done again.

If it is not done then it is medically inappropriate.

And simply doing it quarterly is never going to do [129] anybody any particular good.

This is spelling it out inappropriate medical practice by regulation. It doesn't mean that you couldn't do the appropriate as well but this is regulating inappropriate practice.

Under the same section there, Section 4—

Q We are in 205.230?

A Yes; 205.230(a). It says: "A physician"—

THE COURT: Could I go back to Subparagraph 5 before we go into anything else.

MR. GILBERT: Sure.

THE WITNESS: Certainly.

THE COURT: What do they review on the quarterly pathological reports from procedures performed by each physician on the staff?

What is the purpose of the review?

Is there any indication in anything as to what they are supposed to be doing with that review?

THE WITNESS: Could I confer with my counsel for a minute, your Honor, in response to that?

THE COURT: Yes. I just wanted to see what that was intended to mean, if you knew.

(Witness and Mr. Gilbert conferred.)

MR. GILBERT: May he step down for a minute so that we can go over this?

[130] THE COURT: Yes, he may.

(Brief interruption.)

THE COURT: I mean, I can imagine what they would review if it was, say, the tissue from somebody. For example, I mean, if it was some tissue as to a tumor or something like that—you can put this on the record—if it was some tissue from a tumor which was removed on the basis of its being cancerous or something like that but I am wondering, in connection with the abortion procedure that you have testified to this morning, what would be the medical purpose of a Tissue Committee reviewing, at least quarterly, pathological reports from such a procedure.

THE WITNESS: I can't speak for the state, your Honor. It is my understanding—the regulation, as I see it, is extremely vague and I have as much trouble as you do or as you are asking as to truly understanding it.

THE COURT: Yes.

THE WITNESS: It is my understanding, without qualifying to speak for the state, that this is a way of assuring that there is a pathology report to match each patient, but I cannot—I can only speculate as to that as being my understanding of the regulation.

THE COURT: Would the purpose be to see to it as to the age of the fetus or something?

THE WITNESS: No, that's not the purpose.

[131] THE COURT: It wouldn't show by the tissue?

THE WITNESS: No.

THE COURT: All right. You may proceed.
BY MR. GILBERT: Q I think you were speaking before about Subparagraph (a)(4) of Section 205.230.
A Yes.
Q And what is there about that provision?
A Okay. This is a—
Q That is, what is there about that paragraph or that provision that is burdensome and/or unnecessary?
A This paragraph specifies that a physician who shall have privileges in an Ambulatory Surgical Treatment Center shall have essentially equivalent practice privileges in at least one Illinois-licensed hospital.

Now, first, there is nothing specific to having privileges in a hospital that qualifies for the types of procedures that we are talking about here, namely, first and early second trimester abortions.

My own hospital, of which I am a member of the active staff, prohibits first and early second trimester abortions, except in very rare circumstances.

Similarly, there is nothing about having those privileges that necessarily qualifies one to practice in an Ambulatory Surgical Treatment Center and to do that type thing. [132] In other words, this is, as with several other reg's that we will probably come to, although creating the independent ASTC, then ties it to a hospital and mandates certain things from a hospital in terms of the operation of an ASTC, which really don't have any relevance.

Going together with this Section 3, which specifies that this Consulting Committee shall act as a Credentials Committee, sets forth the method of determining credentials, and then, as I said, negates it all or takes that privilege away in Section 4, which says that, basically, a hospital is going to determine credentials.

And if this seems like a confusing contradiction, it is somewhat, and, as I say, in actual practice it is a very

potentially burdensome—or it ties the ASTC to a hospital.
Q Maybe it would help in our understanding if you could answer this question: This notion of this qualified consulting committee which provides credentials and reviews policies and procedures, and the like, does that remind you of anything else in your medical experience?
A It is very, very similar, okay, in many ways to the Tissue Committee in a standard hospital, a combination of the Tissue Committee and the Credential Comittee in a hospital.

Interestingly enough, the Tissue Committee in a standard hospital, the requirement for such has now been [133] dropped by the Joint Commission on accreditation.
Q You are talking about the Joint Commission on Accreditation of Hospitals?
A Accreditation of hospitals, yes.
Q Well, is there anything else in 205.230 that you would like to point out at this time?
A Yes. A second point is as to Section (b), then, which relates to the designated medical director.
Q What is there about that section that you consider unnecessary, inappropriate or burdensome?
A The entire section is so vague as to be difficult—well, the section is attempting to relate to a wide variety of possible circumstances the concept of a medical director who is going to oversee all of this and it doesn't apply in, for example, an ASTC, I mean, in a situation such as my own, and it may be inappropriate in a situation different than my own.

But I can state categorically that it basically doesn't even apply in a situation such as my own.

I have knowledge of one ASTC, direct knowledge of one ASTC in the state where the medical director actually does not do—this is an abortion-providing ASTC—where the medical director does not do any abortions, is not

medically qualified under the definition here of "credentialing, that is, having privileges in a large hospital, and is a medical director because the clinic must have a medical [134] director.

Now, if this sounds confusing, it is, but it is this sort of thing that this thing breeds.

Q I take it that none of these provisions of Section 205.230, "Standards of Professional Work," are the kinds of standards that are imposed upon physicians who are just operating private practices—

A No.

Q —imposed by anyone, to your knowledge?

A No, no.

Nor are they medically necessary for a competent physician to continue to practice competently.

Q All right. Why don't we turn to 205.240, "Policies and Procedures Manual."

A All right.

Q Now, is there anything about that provision that you consider unnecessary or burdensome or inappropriate?

A The only burdensome part in this, really, is that it refers, then, to the Consulting Committee and the medical director and all of these—which I feel are unnecessary, okay? I mean, to have a policy, or for the benefit of this hearing, to have a Policy and Procedure Manual, per se, depending upon, if it fits the scope of the practice, is appropriate. I don't know if I said that just right.

Q Well, is the Policy and Procedure—well, you mentioned [135] "fits the scope of the practice," and it would, in your opinion, any competent licensed physician who had the kind of practice that required a Policies and Procedures Manual have such a manual in his practice, or in her practice?

A Yes, they would.

Q As a matter of standard medical practice?

A As a matter of standard medical practice; as a matter of standard medical and administrative practice, yes.

Q How about 205.310, "Personnel Policies"?

Is that something that is necessary for the safe performance of first and early second trimester abortions in a facility like yours?

MS. KREISEL: Excuse me. At this point, your Honor, I would say that this is one of the sections that we were informed that you were not challenging. I had that on my list.

MS. CONNELL: Which section?

MR. GILBERT: I am sorry. I have got it as—

MS. KREISEL: 205.310.

MR. GILBERT: I have it right on my list from our letter to you. May 11.

MS. KREISEL: I have a second list which said—this is Miss Connell's writing—that these are the ones you are not challenging.

MS. CONNELL: Yes. You missed one.

[136] MR. GILBERT: Oh, I did? All right.

MS. KREISEL: Do you want to look at my second letter?

MR. GILBERT: That's fine. All right. We will just go on to another.

THE COURT: Okay. Fine.

BY MR. GILBERT: Q Let's turn to another section.

Those are a few examples of some of the things from that first section, the first, whatever it was, the first subpart—was that Subpart (a), (b), and (c), I believe, or (a) and (b).

Well, anyway, let's turn to Subpart (g) of the Ambulatory Surgical Treatment Center Regulations.

MR. GILBERT: And I should state to the Court or for the Court that we are not saying that all—and Subpart

(g) starts with Section 205.710—and I skipped over several provisions but by no means are we saying that those are all medically necessary and that they do not burden Dr. Ragsdale's practice and the practice of other physicians but I think that we are just trying to single out some of it by example and I would just point that out.

THE COURT: All right.

BY MR. GILBERT: Q Subpart (g) is entitled "Additional Requirements for [137] Facilities in which Obstetrical/Gynecological Procedures are Performed."

Now, Dr. Ragsdale—

MR. GILBERT: And I should note for the record that every provision of Subpart (g) relates to one particular obstetrical/gynecological procedure and that is abortions and the term "abortion" appears in every particular provision of Subpart (g) even though it doesn't appear in the title.

THE COURT: All right.

BY MR. GILBERT: Q Let's turn to Section 205.710.

A Yes.

Q Which says "Abortions."

I will read it and then I want you to comment on it:

"Abortions shall be provided to the public with the same standards of safety, effectiveness and regard for patients' rights as any other health service."

Do you consider that provision to be necessary, as a medical matter?

A That's simply a statement about—

MS. KREISEL: Excuse me. I'm going to object to that. That's not on the list either.

MR. GILBERT: I am sorry, our list says that we object to all of Subpart (g), which relate specifically to abortion procedures.

* * * * *

[139] * * * THE COURT: Well, is your whole argument on all of them that it is medically unnecessary because there are other regulations that already require it?

MR. GILBERT: No, our argument on them is that they are either, number one, medically unnecessary because they are obvious and any medical practitioner would be able—would do what is required as a matter of competent and normal medical practice and, number two, that some of them are medically unnecessary altogether, and, number three, that some of the provisions are actually medically inappropriate.

THE COURT: So, you have got the same argument—

MR. GILBERT: It is the same argument throughout this act.

THE COURT: Well, why would you have left out Subparagraph (g) when it deals with abortions?

MR. GILBERT: Well, we did put Subpart (g) in. He's just talking about Section 205.710.

THE COURT: Oh, that's the only provision?

MR. GILBERT: Frankly, 205.710, on its face, I mean, certainly we don't challenge the fact that abortions shall be provided to the public with the same standards of safety and effectiveness and regard for patients' rights as any other health service.

Obviously, Dr. Ragsdale agrees with that statement. [140] We agree with that and I suspect everyone in this room agrees with that statement.

However, the thing that we want to point out, and maybe we should just do it by argument later and perhaps it is not necessary for Dr. Ragsdale to testify as to it but I thought that, for the sake of completeness, it just needs to be pointed out that you—you don't need to regulate this type of thing. This is the kind of thing that any competent medical practitioner would do.

THE COURT: Under the Canons of Ethics that he operates under or under the common law?

MR. GILBERT: Absolutely, and under the Medical Practice Act in general which licenses physicians.

THE COURT: All right.

MR. GILBERT: And I don't think that the defendants are prejudiced by our bringing this out.

THE COURT: I really don't think your main argument as to the validity of all of these sections or these matters is going to rest on this particular provision.

MR. GILBERT: No. So why don't we go on.

THE COURT: All right. Why don't we move on then.

MR. GILBERT: We will go on. Let's go on from there.

THE COURT: In other words, there is some, of necessity, redundancy throughout any statutory or regulatory [141] scheme and I don't know that that, in and of itself, is enough to make it invalid, and I think that you don't want to spread—I mean, I hope that we don't have to deal with every single regulation, that's not really, I don't think, the main thrust of your case.

MR. GILBERT: No, it certainly is not.

I think, though, what this points out is, is the fact that abortions are singled out.

I think that, you know, it is clear from reviewing the document that there is no similar provision with regard to any other medical procedure in this entire document.

Indeed, there are no other provisions that even—other medical procedures that are even mentioned in this document other than the procedure of an abortion.

THE COURT: Or obstetrical procedures.

MR. GILBERT: Or obstetrical procedures, right.

THE COURT: Yes.

BY MR. GILBERT: Q Well, let's try to move it along then. Let's move on to some of the other provisions here.

Let's turn to 205.730, "General Patient Care," Dr. Ragsdale.

In the counseling provisions there in 205.730(b), you testified before—

A I think that we dealt with those. I think that we [142] covered that. Maybe we can save some time if we don't go back over that.

Q Okay. Then we will go on. Let's go on from there.

A There are other areas in there but—

THE COURT: Well, if there are other arguments—the one argument that I recall is that it may not be appropriate if it is to require counseling of other alternative well, other alternatives, if the abortion is necessary for the woman's health and safety.

If there is any other argument I do think that it ought to be spelled out. We don't need to go into elaborate detail but just to indicate what other provisions might be found to be invalid.

BY MR. GILBERT: Q Dr. Ragsdale, is there more in there that you have difficulty with?

A Well, there are several other areas that can be a problem.

Now, first is Section—all right, we are on .730(a), Subparagraph 2. There is no quarrel with the need to perform appropriate—no, wait a minute, Subsection 1 not 2.

Q All right.

A There is no disagreement with the need for performance of appropriate laboratory tests, in this instance specify a Rh factor. The definition of what constitutes a "qualified [143] laboratory technician" is a point specifically at issue and the term is used in that regulation.

In Subsection 3 there—

Q What do you mean it is "a point specifically at issue"?

THE COURT: You don't know what that means, is that what you are saying?

THE WITNESS: I know exactly what that means, okay?

THE COURT: Oh, all right.

BY MR. GILBERT: Q You are saying that you know what it means to you or you know what it means to the state?

A No, the term "qualified laboratory technician" is defined in the regulations here.

Q Do you consider—where is the definition of that in the regulations? Is that in the very first section—that's in the very first section, I believe, isn't it?

A I believe in the first section they refer simply to "qualified laboratory"—well, I am not sure if it is in—no. Okay.

It is under—if anyone else can find it sooner than I, please do.

It is under the section on—

Q How about 205.350(a)?

A Yes. That is correct.

Q Okay. Is it necessary as a medical matter for a qualified [144] laboratory technician—

THE COURT: Well, that defines a "qualified medical technician." I don't know that that is the same.

THE WITNESS: When that term is used later in the act and as the department interprets this in practice, the two are referred to as the same.

BY MR. GILBERT: Q And you know that just from the interpretation and practice?

A I know that very specifically from the department's interpretation relative to my own facility, yes.

Q All right. And—

THE COURT: Now, is that required of regular hospitals? Does everybody have to be—

THE WITNESS: The qualifications of a laboratory technician are usually determined by the pathologist or physician in charge of the procedures being done, your Honor.

Now, in a physician's—

THE COURT: But a hospital has a lab and they are not all qualified laboratory technicians who work in the lab, is that right?

THE WITNESS: By this definition, no, they are not, your Honor.

THE COURT: So, I don't believe that the hospitals normally have only qualified laboratory technicians and so [145] this means that you have to have a special procedure then for abortions and that you would have to have your lab tech who is running the lab conduct these, I mean, this particular test, is that what you are saying?

THE WITNESS: That is correct, your Honor.

And, as you have observed, that's not—I have been informed by my consulting pathologist that for the nature of the procedures that we are doing, that this is an unnecessary qualification.

THE COURT: I happen to have a daughter who is a qualified, I guess, medical technician who went to school, and so on, but not everybody in a lab, as I understand it, has such qualifications or such certification and, routinely, people without that are utilized in hospitals to run the tests and are so utilized.

It seems to say that you would have to have only the qualified laboratory or medical technicians determine, at least, Rh Factor blood tests for every patient, which, it would seem to me, would require a higher level of certification for a lab being utilized for abortion purposes than it would for labs for any other surgical procedure, it would seem to me.

Is that what the argument is about this? Or does Illinois require this for everything but, they, I mean, in practice it is not carried out?

THE WITNESS: It is never—nowhere it is required [146] in a physician's office, and you have described the hospital situation, as I understand it, very accurately, your Honor.

THE COURT: Well, I'm not here to testify, I'm just trying to speed things up here.

MR. GILBERT: Yes.

THE COURT: So, if counsel will proceed.

MR. GILBERT: Yes, your Honor.

BY MR. GILBERT: Q Dr. Ragsdale, is there anything else in .730 that you want to discuss?

A Yes. There was one other section on that in the, I mean, in several of these, what time, in Paragraph (a), in the subsection there, simple statement of time shall be allowed—well, I don't, I mean, what "time" is is fairly nebulous but, very specifically, under Subsection (b), Subparagraph 2, Subparagraphs (a) and (b): "Counseling shall be done by a person qualified to," and listing several things that a counselor should do, and then (b), "Demonstration of such counseling qualifications shall be required by the department."

Nowhere is there any specification as to what "counseling requirements" might be required or, very honestly, of the department's expertise in determining what "counseling requirements" should be required and, you know, in practice, this is an objectionable thing.

* * * * *

[152] MR. KEMMER: Objection. Leading, Judge.

THE COURT: Well, I don't think that he is suggesting an answer. It is more directory and I will overrule the objection.

I will permit the witness to answer.

BY MR. GILBERT: Q Would you please answer the question.

A All right.

Q Did you answer the question? You have to—

A Well, would you repeat the question. If you would just repeat the question that I am to answer.

Q Oh, all right.

The question is, is 205—are the provisions of 205.1360 regarding clinical facilities medically necessary for the performance of first trimester or early second trimester abortions?

A Not as stated.

Q And will you tell us why they are not necessary as stated.

A Okay.

Q And then what, in effect, they do.

A Okay. All right.

It is necessary in performing a first trimester abortion to have some room in which to do it, thus, an examination room or procedure room or "room" by whatever name [153] you may wish to call it, and that is necessary, medically. I have testified to that earlier.

Now, it is necessary to have some place in the facility for the physician to wash his or her hands; it is necessary, you know, as part of performing abortions.

It is necessary to have some space for the patient to recover following the abortion procedure. Okay.

Now, whether this is a separate space or the same room in which the procedure is performed is a purely optional matter. These items, to this degree, are necessary as they—

Q Well, let me interrupt you for a moment.

A All right.

Q Let's talk about these particular provisions.

A Okay.

Q For instance, it says under (a) of 205.1360, "Examination rooms. Each examination room shall have a minimum clear floor area of 80 square feet and a minimum dimension of eight feet," whatever "minimum dimension" means.

Is that medically necessary for the performance of abortions?

A Okay. The dimensions specified are not medically necessary.

Q How about procedure rooms? "Procedure rooms must have a minimum clear area of 250 square feet and a minimum dimension of 14 feet."

[154] Is that medically necessary for the performance of first trimester and early second trimester abortions?

A In relation to first trimester abortions it is not only medically unnecessary, it is medically poor.

Q Why is it "medically poor"?

A In that it creates a room that is actually too large for the procedure at hand and the people who will be in it and it creates an emotional environment which is an emotionally disturbing environment for the patient to be in.

Q Now, these minimum clear floor areas and minimum dimensions are those the kind of dimensions that you find in a doctor's office?

A The dimensions that you would find in a doctor's office can be extremely variable and will be at the discretion of the physician.

Now, you might find some of these but they are not required or mandatory or necessary.

Q Are these the kinds of dimensions that you would find in a hospital, from your experience?

A Some of them might be found in a hospital, particularly the 250 square feet room, yes.

Q And before you were testifying about your procedure rooms and would you again tell us how large the procedure room is that we heard you testify about before and which was pictured in Exhibits, I believe, 2 through—or 4 through 9.

[155] A The room which was in the exhibit was seven feet nine inches by ten feet.

THE COURT: So, that's roughly 80 square feet?

THE WITNESS: That is correct.

BY MR. GILBERT: Q And that is a procedure room?

A That is used as—yes.

Q And I believe you testified that you have performed a large number of safe first and early second trimester abortions in that room?

A That is correct.

THE COURT: Now, all of this, of course, goes to, if nothing else, increasing the cost of performing an abortion; will there be any testimony as to what plaintiffs' view or anybody else's testimony, I mean, concerning the result of these regulations on the potential or the actual increase of costs of performing an abortion for an individual?

BY MR. GILBERT: Q Dr. Ragsdale, do you—

MR. GILBERT: Well, Dr. Ragsdale is prepared to testify about the additional costs that this will cost him in his practice and, of course, that will be passed on to his patients, so we will be getting to that.

THE COURT: There will be some testimony that will break it down on a per patient basis, some kind of testimony [156] of that sort?

MR. GILBERT: I am not certain that he has that actual figure in mind but—

THE COURT: Because there would be two effects as to that, as I see it, and one would be the chill on an individual for economic reasons, as to doing abortions, and another would be the effect on the individual patients who have the right to have an abortion.

MR. GILBERT: Well, there are a couple of elements here, your Honor. One is that there is a kind of a threshold requirement, that the costs are so high to set up one of these facilities—

THE COURT: Yes, I understand.

MR. GILBERT: —to set up one of these facilities that people like Dr. Ragsdale are going to go out of business.

THE COURT: Yes. That's looking at that aspect and—

MR. GILBERT: And, number two, there is the additional cost, if he could afford it, to set one of these up, in which case those costs would be passed on to his patients.

THE COURT: That is correct.

MR. GILBERT: In order that, given that this is a preliminary injunction hearing, and in order to limit the proofs, we decided not to bring in a cost accountant to come in and show the per-patient basis.

[157] Now, when it comes time for a final hearing in this matter, at that point I think that we will bring somebody in, and as a matter of fact, we think that for purposes of a preliminary injunction that Dr. Ragsdale is competent to testify about the increased costs that he would have incurred if he were to comply with the requirements and then we can infer from that that he will testify that those costs will be passed on, will have to be passed on to the patients, that's the only way that he can cover it. And that that will increase the costs to the patients.

THE COURT: Will there be some specificity to that?

MR. GILBERT: We will provide you with as much specificity as we can at this time without a cost accountant.

THE COURT: If there was just a ten cent increase, why, obviously, that would be minuscule but it seems to me that there would have to be some testimony to show that that would be a relevant burden.

MR. GILBERT: Right. Well, we will provide as much specificity as we can in this hearing for you, your Honor.

We do not have a cost accountant prepared to testify at this time. We don't have such a person to testify to those figures.

THE COURT: That's why I am asking, since he is the one running the facility, why, it would seem to me that he would have enough of a foundation to be able—

[158] MR. GILBERT: I think that he will be able to provide testimony as to that. He will be able to provide some evidence on it.

THE COURT: As to what he would have to charge, yes.

MR. GILBERT: There will be some evidence on that.

MS. CONNELL: Your Honor, if we might just have a moment? I am sorry.

THE COURT: Sure.

(Brief interruption.)

MR. GILBERT: Just as a matter of presentation, we could go into the costs but I think that it might help at this point if we were to complete, at least, the physical costs, the physical cost requirements.

THE COURT: Yes. The only reason I interjected that at this point is that, obviously, the size, the required size of the procedure room would directly affect the cost, it would seem, of the operation and so I just thought that it would be appropriate to mention it while the witness is still on direct, to see if he would be covering that.

MR. GILBERT: Right. And the doctor—

THE COURT: Since it is covered in some of the cases that have been cited.

BY MR. GILBERT: Q Dr. Ragsdale, to build a larger room of this sort would [159] cost you—well, would it cost you more to build a room of this sort?

A Yes.

Q Let's go through some of the other building and structural requirements and then maybe we can go into the

general nature of what you know about the additional costs.

A All right.

Q So, that was 1360 and so now let's go to 205.1370 under "Support Service Areas."

A Okay.

Q Under Subparagraph (a) it mentions that: "A control station shall be located to permit visual surveillance of all traffic which enters the operating suite."

Is that something that is necessary for the performance of a safe first or early second trimester abortion?

A This is a direct description of something that you would encounter upon entering the operating suite at a hospital, okay? I mean, that's exactly what that is.

Now, it really has no relevance to the type of facility that we are talking about here for early first—that we are talking about as to first or early second trimester abortions.

MR. GILBERT: I would point out to the Court that Exhibit A to our brief has a list of the—

[150] THE COURT: That is correct.

MR. GILBERT: —a list of the provisions here that directly track the Hospital Licensing Act of Illinois.

THE COURT: Right.

MR. GILBERT: And these, particularly 205.1370, has just lifted the very language out.

The term "operating suite" doesn't appear anywhere else in this entire ASTC Act regulation except in the provisions that are directly out of the Hospital Licensing Act.

BY MR. GILBERT: Q Now, these other provisions of 205.1370, are those the kinds of things that you need in your facility to provide safe first or early second trimester abortions?

A Without going through them item by item, which I will do if you request—

Q Why don't you just generally tell the Court what they do.

A Sure. All right.

Again, as stated earlier, it is necessary for the physician to have a place for hand-washing. Now, we have already specified three different places for hand washing in two places, in two pages of rights. We have said that that is right.

We need a place for hand washing but we don't need a "scrub sink" as it is normally interpreted in a hospital [161] environment.

There needs to be a work room of some type. Whether it needs to be the formal clean-and-soil work room of a hospital or whether something less dramatic, as to whether something less dramatic will suffice, that depends upon the extent of the facility and the number of procedures being performed. But it can't be codified, per se, by regulation.

Q Now, you are on the staff of Rockford Memorial Hospital—

A Yes.

Q And you have practiced in hospitals before.

A Yes.

Q Now, are these provisions of 205.1370 provisions that set up something that, in your mind, is like a hospital?

A Yes. As I said at the outset, this is a description of a hospital operating area.

No one will do any procedure without a way to sterilize instruments, all right, and so some of these belabor the obvious and, obviously, are true statements.

Now, in the type of facility that we are talking about, one for first and early second trimester abortions, referring specifically to Subsection (n) here, there is no particular reason to have a janitor's closet exclusively for the

operating room—or for the surgical suite, rather, which, again, is a hospital-type of term.

In Section—

[162] Q I take it that these types of facilities are not present in your average doctor's office?

A No. Sections (k), (l), referring to staff locker rooms and patient change areas, again, are hospital facility type environments. They are unnecessary to perform abortions.

These consume large amounts of space and equipment and they are expensive to construct. And they have no realtionship of any type to performing an abortion in an out-patient facility.

THE COURT: You are talking about (g) through—

THE WITNESS: I am talking there specifically—

THE COURT: (g) through (l)?

THE WITNESS: I am talking there specifically about (k) and (l), your Honor.

THE COURT: How about an "anesthesia storage facility"?

THE WITNESS: Well, in the sort of environment that we are talking about, we use no general anesthesia and so the provision becomes irrelevant, and I am not competent to speak to an environment where general anesthesia, I mean, you know, if somebody were using general anesthesia then it would become relevant but we are talking about first and early second trimester abortions and local anesthesia.

THE COURT: Right. So, (h), (i), (j), then, are not—well, then, "a separate storage area," and—you start [163] with (j)?

THE WITNESS: Yes. But that's not—

BY MR. GILBERT: Q And I take it that (k) as well you consider to be a problem?

A Yes.

Q Let's go through the numbers here. Do each of the subparts in 205.1370 add additional expense without adding anything in the way of additional safety to the procedures that you speak of?

A Except as I noted, that certain facilities or certain basic ideas or abilities are required—each of these sections create additional costs, space and cost requirements, and, thereby, increase the cost of the facility, without increasing safety, yes.

Q Okay. Fine.

Let's go on to 205.1380, Subpart (b)—and Subpart (a) doesn't apply to you at all, is that accurate?

A That is correct.

Q "Radiographic Suite", you don't have X-rays involved in your practice, is that right?

A That is right.

Q So, now, Subpart (b), "Laboratory suite shall contain the following minimum facilities," and it goes through a list of five things.

[164] Are those things necessary for your practice?

A Well, an office performing first and early second trimester abortions doesn't have a "laboratory suite," it has an area for laboratory procedures but a "laboratory suite" with all of the things specified in 1 through 5, you know, is not necessary and is expensive and space-consuming to produce.

Q Do you know what the term "laboratory suite" comes from?

A I do not, of my own specific knowledge.

THE COURT: Referring to the Hospital Act again?

MR. GILBERT: Yes. It refers to the hospital—1380(b) is directly out of the Hospital Licensing Act.

THE COURT: Yes.

BY MR. GILBERT: Q What type of laboratory activities go on in your practice?

A Okay. We are talking about basically performing an hematocrit or hemoglobin, a test for the red blood count; a Rh Factor, which is a very simple matter of a tube test, a pregnancy test and a very simple urinalysis by a dip-stick method, these four basic laboratory tests.
Q Are those relatively simple laboratory tests?
A These are extremely simple tests, yes.
Q Could you perform them yourself?
A Yes, I can perform each of them myself.
[165] Q Are you a qualified medical technician within the meaning of the Ambulatory Surgical Treatment Center Act?
A No, I am not.
Q To perform those simple tests is it necessary to have a laboratory suite as mentioned in 205.1380(b)?
A No.
Q With all of the various procedures that are mentioned there and facilities?
A No, it is not.
Q Would such a suite require additional expense on your part if you had to put one in your offices?
A As stated there, yes, it would.
Q An additional space?
A What?
Q Would it require additional space?
A Yes.
Q Let's go to 205.1400, which is entitled "Details and Finishes," and it is two and a half pages of Subparts (a) through (y), most of which is shown on Exhibit A to our brief, that they are directly out of the Hospital Licensing Act.
A Yes.
Q Turning to (a), do you need to have public corridors of five foot width in your facility, except those—well, let me back up.

[166] The corridors where patients are transported—"The corridors where patients are transported and stretchers and carts shall be eight feet wide."
Is that necessary?
A In a facility like we are talking about we do not use stretchers or carts and so the eight foot requirement should be irrelevant, although I indicated previously some discussions with the architects of the Department of Public Health and this is a requirement that they are very uneasy about giving up and so even if you say that you don't have stretchers or carts it is one that they potentially may require you to follow.
Q Well, this eight foot corridor, is that something that you would find in a hospital?
A That's a hospital-type corridor in a surgical suite used to transport patients on surgical carts.
Q And when your patients come into your facilities for the performance of first trimester and early second trimester abortions and when those procedures are performed and after those procedures, do your patients—do you transport them on stretchers or carts from the counseling room to the examination room to the procedure room to the recovery room?
A No. The patients are ambulatory at all times.

* * * * *

[170] * * * Q Are those two foot eight inch doors, is that a normal door width for a physician's office, in your experience?
A That is a very standard door.
Q A standard door?
A Yes.
Q And the three foot or three foot eight inch door widths, are those standard door widths?
A Three feet is a standard door width but three foot eight is not a standard door width.

Q Now, why don't you look through the rest of Section 205.1400.

Are there other provisions in there that you consider to be unnecessary?

A All right. Let me see.

(Examining.)

Well, the remainder of these requirements are, in the main, the sort of thing that will be accomplished when something is properly constructed, okay?

There are some of these which tend to belabor the obvious, and I would refer to Section (k) regarding how one shall dry their hands, okay, with, you know, either air-drying [171] or paper towels, excluding all other methods.

Now, this seems to be a little knit-picking at times. There is one—

THE COURT: How about minimum ceiling height? Does that create a problem for you, the eight feet?

THE WITNESS: Well, minimum ceiling height of eight feet if it is interpreted to mean, you know, seven-eleven as eight feet, which is generally acceptable.

An eight foot ceiling height is a fairly standard requirement for almost any building that you are going to encounter and, you know, that is not a burdensome sort of requirement.

THE COURT: Okay.

BY MR. GILBERT: Q How about—

A Several of these—well, Section (w) is one which is particularly, in a way, counter-productive in the realm of first and early second trimester abortions. Now, it sounds very sensible to have ceilings that can be washed easily and that are smooth-finished as to a procedure room—and we are going to talk about air a little bit later as well but the bacteriology of abortion does not involve air-born bacteria, it involves direct contamination from bacteria already present in the patient's body. So, the air-born

bacteria or things of that sort are not a problem in abortion.

[172] By the nature of the procedure, noise is a problem. It is a big problem. Anything that eliminates the acoustical—anything as to an acoustical-deadening environment, as to having that in an abortion environment, that is helpful and anything else is patient-irritating and counter-productive.

BY MR. GILBERT: Q So, you are saying that you cannot have an acoustical ceiling because of Subpart (w) of 205.1400?

A That is right. And, interestingly enough, the smooth ceiling costs more, by a big amount. We are talking about three times the cost for the ceilings that are smooth-finished versus ceiling panels that are acoustical in nature.

Q Let's go on to 205.1410.

In particular I call your attention to Subpart (b)—well, no, that's Subpart (d), which says "Elevators and dumb waiters."

A Okay. Let me state for the purposes of this hearing that I have no objection to requirements of fire safety and I would, you know—we are going through the first part of this and this is an important feature, and, you know—

Q Okay. We will talk about elevators.

It says: "All ambulatory surgical treatment centers located above the first floor of the building shall have an electric or an electro-hydraulic elevator."

A Yes.

[173] Q Is it necessary, in your practice, to have an electric or an electro-hydraulic elevator if you happen to be on the second floor of a building?

A No. By definition, all patients entering and all patients leaving are ambulatory, okay?

In the main, the patients are young, healthy women and they are perfectly able, and most of them do in the ordinary course of their regular lives, walk up one flight of stairs.

There are, nationwide, many facilities which are located above, on the second floor, which do not have elevators. This is not a medically necessary requirement.

In the event of an emergency such as either fire or patient transport—in fire you would specifically be prohibited from using the elevator and, in the case of emergency patient transport it would be faster to use the stairs and would be preferred.

Now, I might add also that an elevator is a burdensome and expensive piece of equipment to install. A one-story elevator costs approximately, depending upon who is building it and where it is being placed, somewhere between $50,000 and $80,000 to install.

* * * * *

[175] * * * Q Why isn't it medically necessary in the performance of a first trimester or early second trimester abortion to have these kinds of strict air flow requirements?

A Well, this is why I brought up the air-born bacteria matter a few minutes ago, and also it goes back to my demonstration of the procedure this morning.

The procedure of abortion—infection is one of the complications, as we know, but the infection in abortions does not come from air-borne bacteria. It is not like catching a cold or somebody coughing into a patient's [176] surgical incision. This is not where infection comes from in abortion.

If you will recall, we were discussing an instrument called a speculum and we were working with such an instrument, with a space of about one inch in diameter. Okay.

The infection doesn't come from the air and so these maximal air handling requirements are simply irrelevant and are not necessary in abortion.

Q Now, we've touched on a few of these physical requirements, on the air-conditioning and heating systems and on the finishes on the ceilings, the corridor widths, and the like.

A Yes.

Q Now, you testified before that you lost your lease and after you lost your lease at the Rockford Medical Center did you check into obtaining another facility that met the requirements of the Ambulatory Surgical Treatment Center Act?

A I have investigated a number of areas and a number of sites and—yes, in response to your question.

Q And were you able to find another site in the Rockford area that met these requirements that you could rent?

A No.

* * * * *

[183] * * * Q Well, let me cut you off there. I don't want you to have to go through all of the details.

A All right. Yes.

Q And I don't think that that is going to help here.

A All right.

Q So, I mean, did you have to file any application forms?

A Yes. We submitted an application for whatever—what I call a "Certificate of Need."

Q And can you tell us—

A Which was simply—

Q Well, first, can you tell us about how much in the way of paper that you had to file.

[184] I mean, was it—

A All right. Yes. Well, it took me five continuous days' work to complete. And it was, you know, about yea thick altogether (indicating).

Q All right. What other process did you have to go through in addition to filing those forms?
A Well, we had to obtain the—
Q And by "yea thick," for the record, what was that about?
A I would say about an inch.
Q An inch or two of papers?
A Yes.
Q And after filing those forms, what kind of a process did you have to go through?
A All right. The basic application was filed with the state. As a part of the—and the state agency that I am speaking of now, as a lay person and this process as I have been given to understand, as to that matter, but the state agency reviews the application for various factors which they deem relevant. The application is also referred to the Regional Health Planning Board for their review.

The first step in the Regional Health Planning Board's review is to publicize the fact that a Certificate of Need has been—that an application for a Certificate of Need has been received.
Q Publicized to whom? And how?
[185] A To any individual whom the Regional Health Planning Board considers might have an interest in the issues—in any issues related to the Certificate of Need.

In my own instance this meant that the Health—that Comprehensive Health Plan, Northwest Illinois, mailed to everyone in the nine county Northwestern Illinois area whom they considered might have some interest in abortion; i.e., had expressed an interest at any time in the past, they mailed notification that my facility was in the process of moving and a brief statement as to why; i.e., that I had lost my lease and that I would be moving.

Q Did that notification indicate the type of facility that you had and the type of procedures that are and were performed in your facility?
A Yes, it did.
Q Did it mention abortions?
A Yes.
Q All right. Why don't you go on as to what the next step of the process was after that publication.
A Yes. Okay.

If the Health Facilities Planning Board receives a request from an individual for a public hearing then they must hold a public hearing and, that is so, naturally, if they receive such a request.

There was—
[186] Q Was there a public hearing held?
A There was a public hearing held.
Q Where was the public hearing held?
A The public hearing was held in the auditorium of the Flinn—that's F-l-i-n-n—Middle School in Rockford, Illinois.
Q Were there more than a few people at this public hearing?
A There were 1200 people at the public hearing.

And at the—
Q And what happened? What happened at the public hearing?
A First of all, for two weeks—or for the ten days or two weeks prior to the hearing the whole issue of the abortion clinic moving had been a center of attention in Rockford, Illinois, and I believe I can state this very accurately by noting that the issue had been on the front or the second page of the newspaper and on the 5:00 o'clock news of all of the local television stations continuously during this period of time.

The first site that we had proposed we had already lost because the individuals who were going to lease to me

had been pressured to the point where they could not—They could not deal with it.

MR. KEMMER: Objection.

THE COURT: I will sustain the objection as to the "pressured so that they could not do it," and that will be [187] stricken from the record.

I will require that there has to be further foundation laid before any such testimony might be admissible.

I do think that it could be relevant, if you lay the foundation for it.

BY MR. GILBERT: Q With regard to the first site, now that's the site that you were testifying about before where you had plans drawn up?

A Yes.

Q That you felt that you might have been able to come close to complying with the regulations?

A Yes.

Q Had you made arrangements with the landlord for that site prior to this public hearing?

A Yes, I had.

Q With the publication of the pending hearing?

A Yes, I had.

Q And had you entered into, at least, an informal arrangement of some sort to rent the facility?

A That is correct.

Q Did you enter into a formal lease arrangement with the landlord?

A No, I did not.

* * * * *

[191] * * * BY MR. GILBERT: Q Did the landlord at that time withdraw the site or tell you that he would no longer be able to—would no longer rent to you?

A That is correct.

Q I said an "or" there; do you recall what he said or can you say in your own words?

A I can recall the substance of a very lengthy conversation.

Q I don't want you to testify about that.

A But I cannot specifically—

Q Well, I don't want you to testify as to reasons but was it the substance that he would no longer rent to you?

A That was the substance.

Q Now, did this occur in that period between the public notice of the Certificate of Need hearings and the actual hearing, is that correct?

A Yes, it did.

Q Correct?

A Yes, it did.

Q What happened then at the hearing?

A Well, before the hearing, then, we had to find a second site and so a second site was located and at this time a third party commitment was obtained for a lease for a site on North Main Street in Rockford.

[192] Q You say a "third party commitment"?

A That is correct.

Q You were led to believe that you had a commitment from the landlord?

A That is correct?

Q And between the time of that commitment and the time of the hearing did anything occur with regard to that commitment?

A No, nothing between the time of that commitment and the hearing.

Q Did you present that site at the hearing?

A Yes, I did.

Q Did you present that site at the hearing to the Regional Division or body of the Health Facilities Planning Board?

A Yes, I did.
Q The hearing was held by the organization?
A By the organization.
Q And the name of—
A The organization by the name of the Comprehensive Health Planning of Northwest Illinois.
Q Which is commonly known as CHPNI?
A That is correct.
Q And can you describe to the Court what happened at that hearing.
A I was the first speaker at the hearing. I announced the change in site location and did not, basically did not [193] complete a further sentence due to inability to be heard.
Q Why were you unable to be heard?
A There was a mixture of applause, cheers, cat calls, boos and banners—well, "banners" did not prevent me from completing but there was a mixture of cheers, boos, cat calls, general noise generated from the people in attendance.
Q What did the banners say, if you recall? What did the banners say that were there at that time?
That was in the evening, I think you—
A Yes. That is right.
What did they say?
Q What did they say?
A Well, I cannot recall at this juncture—
MR. KEMMER: Object.
THE COURT: Is there an objection?
MR. KEMMER: Yes, there is, your Honor. I believe that this is irrelevant.
THE COURT: I will overrule the objection.
I do think that the requirement of this particular provision can be a burden on the ability to provide abortions

in the real world and that is what this testimony is about and, on that basis, I will overrule the objection.

* * * * *

[203] * * * THE WITNESS: There was basically no functional discussion of true medical need as defined within the certificate as we think of it within this generally applicable to medical services situation at this particular meeting, I will state that for myself, and there is a summary of the conversations in this particular document which may or may not be in evidence.
I will state for the record that the tone of the discussion was such, and I have said this before, that I was escorted from the meeting by friends who were fearful for my safety, together with my family, and that my daughter was sufficiently impressed by the proceedings that she simply—basically, she cried all the way home.
I would direct your attention within this to a comment, and this is Speaker No. 42 and—
BY MR. GILBERT: Q That's Exhibit 11 you are referring to?
A This is Exhibit 11. This is on Page 36, Speaker No. 42.
Q Does Exhibit 11 contain a summary of what was said by the speakers at this meeting?
A Yes, it does.
[204] Q And you are at Page 36 of Exhibit 11?
A That is correct.
Q Does that exhibit refresh your recollection as to what was said at this meeting by various people?
A I don't need the exhibit to refresh my recollection but it is here and I would refer to that statement by a North Main businessman who bitterly resents having this "rammed down our throats," and asked for a new hearing on the Rockford location and says that property owners have a right to quiet enjoyment of their property and he will see that there is anything but quiet enjoyment of that right.

May I continue or shall I stop?

THE COURT: You are talking about "North Main," which is a business location?

THE WITNESS: That was the second site that I had obtained, your Honor, after the first one collapsed. Okay.

The reason that I specify that comment—if I may continue—is that 48 hours after the North Main site was withdrawn, even though a written commitment had been obtained, and I cannot speak for the individual other than hearsay who withdrew the site but I would note that in the documents we have produced is a letter from that potential lessor to the individual who made this statement indicating—who had no other interest—indicating that the lease site had been withdrawn.

[205] I have had private conversations with the individual who withdrew that lease, if they are not considered hearsay.

BY MR. GILBERT: Q Well, I think that, based on the Court's prior ruling, that the only thing that you could say in the courtroom today is that—is whether or not he did tell you that he withdrew the lease.

A He informed me that he withdrew the lease; he wrote such a letter to the individual identified previously from the deposition and sent a copy to Comprehensive Health Planning of Northwest Illinois.

Q Did the Comprehensive Health Planning of Northwest Illinois reach a decision on whether or not there was a need for your facility in Northwest Illinois?

A They were unable to reach a final decision. The review process had essentially been completed and as far as the review requirements, I was informed, and this document would seem to support—

Q You are referring to Exhibit 11?

A That is correct.

That we had met the review requirements and that, within the terms used, that the need, you know, had been defined.

We were unable to provide this group or the Illinois Health Facilities Planning Board with a site.

[206] Q Who had informed you that you had essentially met the needs?

A I was informed by Mr. Joel Collin of Comprehensive Health Planning and I was informed by the individual who was chairman of the subcommittee dealing with this. His name is in here somewhere and I do not know it at the present time.

* * * * *

[338] * * * Q Is there any way that that particular provision can inhibit the performance of safe first or early second trimester abortions?

A Very definitely yes.

This places the physician's ability to perform a first or early second trimester abortion—

Q Well, let me interrupt you for a moment. I think that we ought to place this in context, and this is the provision that deals with granting specific—that a physician just be granted specific practice privileges with at least one licensed Illinois hospital—

A That is correct.

Q —that performs abortions?

A That a physician must have equivalent privileges at at least one licensed Illinois hospital in order to have a similar privilege in an ambulatory surgical treatment center.

Q Okay. Now, would you again, please, explain why you think that this inhibits the performance of safe abortions.

A Well, this effectively means that—it grants a second layer of credentialing for a simple out-patient procedure,

in order to perform an abortion there has to be a hospital somewhere that performs abortions, number one, and that will grant you the privilege of doing so, number two. And this takes the authority to perform the abortion out of the [339] competency of the physician and transfers it to a hospital, and this is subject to abuse.

Now, this can—

Q Are you suggesting that a physician must have the approval of a hospital before he can or they can perform abortions in an ambulatory surgical treatment center?

A Strictly and literally interpreted, that's exactly what that regulation says.

Q Let's turn to Section 205.540(c), which relates, I think, to the same general topic.

Now, that's the postoperative care provision regarding the requirement of written documentation of a transfer agreement with a licensed hospital or a statement of full admitting privileges in a licensed hospital.

Is that what those terms state?

A Yes.

Q Do you consider those particular requirements to be medically necessary for the performance of safe first and early second trimester abortions?

A At the risk of repeating what Dr. Hern basically just said, I don't think anyone would disagree with the necessity for the availability of a hospital and the desirability of some mechanism for providing hospital care for those patients who might require it.

* * * * *

[342] * * * THE WITNESS: Okay. All right. Right. That's an alternative, but the one that you are describing, what I will describe as "the worst possible scenario," all right, if you transport the patient to the hospital emergency room and say, "Here is this patient" and provide

a summary of care, the hospital—I do not wish to specify which act would be directly involved but the hospital would be required to provide care to that patient under the terms of their license as a hospital.

MR. GILBERT: Your Honor, this is where I think that I can help.

I tender to the Court a copy of the Illinois Emergency Medical Treatment Act, which requires exactly what Dr. Ragsdale just said.

This is Chapter 111 and a half of the Illinois Statutes, Section 86.

(Tendering to the Court.)

THE COURT: Okay. Thank you. Oh, yes, and, unfortunately, they have designed it so that you can't do it that way.

MR. GILBERT: I am sorry. All right.

I will tender a copy to the state's attorney and to the representative of the state as well.

* * * * *

[347] * * * Q Now let's turn to Section 205.—well, I think that we have covered that one before.

Let's go to 205.760 entitled "Reports."

A All right.

Q Now, this is part of Subpart (g) of the Ambulatory Surgical Treatment Center Act regulations which, as I believe you testified before, and is obvious from reading the regulations, apply only to obstetrical and gynecologic procedures and which only, really, mention abortion throughout.

In 205.760 there are several reporting requirements listed there.

Now, I believe that you were in the courtroom yesterday when Ms. Kreisel represented that this section is no longer being enforced, do you recall that?

A Yes, I do.

Q Are you aware that this section is no longer being enforced, or were you aware before Ms. Kreisel spoke about [348] this section in the courtroom yesterday?
A Yes, I was.
Q How did you become aware that this reporting section was no longer applicable to you and to others covered by the act?
A Okay. I became aware of this when my secretary-receptionist informed me, I think approximately a year ago but I could not be—there is a wide variance of dates, possible dates, but approximately a year ago my secretary-receptionist informed me that she had written to the state Bureau of Vital Statistics, or whomever we get the forms from, requesting more forms and she had received a call from them stating that they would not supply us with any more forms and she had asked why and they said, "We are not accepting them any longer," that, apparently for approximately a year or sometime prior to that they had stopped accepting the forms and they had been accumulating them in shoe boxes, is what was stated, and she asked us please not to send them any more forms, or to send any more forms to her or to them, you know.

We said that we did not—we had a requirement that we do this and that before we stopped sending forms we would contact the Department of Public Health to make sure that we were not supposed to be sending them.

I do not know exactly—
Q And did you—
A —do not know exactly—excuse me.
[349] Q Did anyone from the Department ever contact you about this?
A No, they did not.

We asked them subsequently for a written confirmation that this was no longer a requirement. To the best of my knowledge, we never did receive any written confirmation, although our nurse inspector did verbally confirm this on a subsequent inspection visit.

Q Did she confirm that to you at your request?
A That is correct.
Q Did she ever call you or inform you in any other way, without your first requesting it, that this particular provision was no longer being enforced.
A No.
Q Now, let's turn back to, in Exhibit 10, to Page (a)(1) which is at the very beginning and this is the actual Ambulatory Surgical Treatment Center Act itself, the very first page of the act, (a)(1), and let's look at Section 3(a) under the "Definition" section.
A Yes.
Q And that's the definition there of an ambulatory surgical treatment center and it says " 'Ambulatory Surgical Treatment Center' means any institution, place or building devoted primaily to the maintenance and operation of facilities for the performance of surgical procedures or any [350] facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose."

Are you familiar with that provision?
A I am familiar with that provision.
Q Were you in the courtroom yesterday when Ms. Kreisel represented that there has been some kind of a decision of a court that suggests that this provision may not be constitutional?
A That is correct.
Q And were you here when Ms. Kreisel mentioned that that particular provision is no longer being enforced and that at least the portion of that provision that states that the ambulatory surgical treatment center definition applies to facilities in which even one pregnancy termination occurs.

Now, she testified—she, I believe, stated that that was no longer being enforced, do you recall that?
A That is my understanding of what was said.
Q Now, you are also aware of the Medical Practice Act provision, aren't you, that we were discussing right before your testimony here—
A I am aware of that provision.
Q And that provision of the Medical Practice Act states that—well, can you paraphrase your understanding of what that provision means to you as a physician.
[351] A That a physician's license may be either revoked or suspended for performing an abortion other than in a hospital or an ASTC.
Q Do you consider that a pretty serious penalty if that is violated?
A That is a very serious penalty.
Q Now, you have been licensed to practice medicine in Illinois now for how long?
A 15 years, 14 years.
Q And have you ever been informed by the Department of Public Health in writing that the provision of the Medical Practice Act, Section 4433, that requires that abortions be performed in ambulatory surgical treatment centers, have you ever been informed that that provision is no longer being enforced by the department?
A I have never received such information, either verbally or in writing, until this court proceeding.
Q Have you ever received any information—
MR. GILBERT: Excuse me. A moment, your Honor?
THE COURT: Yes.
(Brief interruption.)
BY MR. GILBERT: Q I am sorry. I understand that it is the Department of Registration and Education that enforces this Act as opposed to the Department of Public Health. I stand corrected.

Have you ever heard from the Department of Registration and Education—
A Which act are we talking about now?
Q The Medical Practice Act.
A The Medical Practice Act?
Q Yes.
A All right. I have never received any information from any state agency of any type indicating that the Medical Practice Act, as stated, was not being enforced.
Q How about with regard to the Ambulatory Surgical Treatment Center Act as to that?
A That's what I thought I was answering the first time.
I have never received any information from any state agency of any type indicating that the Ambulatory Surgical Treatment Center Act was not being enforced.

* * * * *

[364] * * * Q And have you—and I believe you testified that you made—well, let me back up. I don't want to—let's just have you say it again.
How many different places have you seen, if you can estimate, in the Rockford area?
A I believe we provided a fairly complete list as a part of the document production.
I will—I could go through them.
Q Well, that's not in the record here.
A Oh, I am sorry. All right.
Q Would it refresh your recollection if I showed you the interrogatory answer that we have provided?
A We have made a preliminary—and by "preliminary" I mean just simply a, what I will call a "recognition consideration" of at least, at least 50 possible relocation sites.
I have personally visited and inspected and done some fairly detailed examination of at least 15 sites. I have done some preliminary planning regarding at least a half a dozen or more of these sites.

We have made a fairly exhaustive survey of the available locations in the Rockford area for my sort of office.
Q Have you tried to find a site where you could perform your practice in compliance with the state acts and [365] regulations that we are challenging here?
A Yes, I have.
Q Have you found such a site?
A No, I have not.
Q Have you made any efforts to determine what it would take to be able to either find a site that you could renovate or to build a site that would comply with the ASTC reg's and the other acts that are challenged here?
A Yes, I have.
Q And, as a part of that effort, have you determined that the costs that it would take you to do so?
A Yes, I have.
Q Have you also as part of your efforts, determined what it is going to cost to build a site or just to move and relocate your present practice to another location?
A I have determined what it would cost to move that comparable to what I am now doing to another location, yes.
Q And have you also determined what it would cost, on a rough basis, to comply completely with the act as written, the ASTC Act?
A Yes, I have.
Q Now, I'd like you to tell the Court about those costs that you have determined for a new site and for a new site that complies with the ASTC regulations.

Do you know of any documents that could help you in [366] presenting your testimony?
A Well, I have prepared two documents for you at your request in this regard.
Q Okay. Let me show you these documents, these two documents—

A I might add, when I say "prepared at your request,"—well, no, that's what I did. All right.

THE COURT: 17 and 18?

MR. GILBERT: 17 and 18.

(Plaintiffs' Exhibits 17 and 18 marked.)

BY MR. GILBERT: Q Dr. Ragsdale, I am showing you two documents marked for identification as Plaintiffs' Exhibits 17 and 18.

Are these the documents that you were just referring to?
A Yes, they are.

MR. FLAHAVEN: Again, your Honor, and I am sorry to interrupt but we have never seen these documents before. They haven't been produced in discovery. They are—

THE COURT: Let me just indicate, there are only 12 more minutes and I am going to have to chop this off at 4:00 o'clock today. You will have ample opportunity to go over this before cross-examination.

So, if you want to make a formal objection you may but I just want to indicate that you will have time before [367] your cross-examination.

MR. FLAHAVEN: Well, your Honor, I object to the use of these. We have had no opportunity to depose him with respect to them. We don't know where these numbers came from. There is considerable detail here.

They told us that they were not going to put on the testimony of an expert economist and now we have it coming in through these late documents.

THE COURT: All right. I think that that is a valid point.

I will give you the right to take his deposition prior to his testifying in detail about this. You can either do it this afternoon or tomorrow morning.

If you come in early you can use the jury room. That will be available.

MR. GILBERT: Your Honor, they have the right to cross-examine him on this.

THE COURT: Well, I know, but they should have the right to talk to him first and so if you—

MR. GILBERT: We can do it right now. Why don't we do it right now so that we can continue on the first thing tomorrow morning if we are going to put it over?

* * * * *

[379] Q I believe you testified on Monday that you have owned a practice for the last—for the last 15 years, is that right?

A That is correct.

Q In the practice of medicine?

A Yes.

Q And in connection with your practice, have you engaged in keeping track of the books and the accounts of your practice?

A Yes, I have.

Q And have you done, what I will call for lack of a better term, "cost accounting"?

A Yes.

Q Have you determined how much your expenses are and how much your patients are paying and determined what kind of a rate you could charge your patients based upon the expenses and the overhead, and the like?

A In broad terms, yes.

Q In broad terms?

A Yes. I have.

Q And have you also been involved in renovations of space?

A Yes, I have.

Q And in that regard worked with, to some extent, in determining the costs of renovations and accounting for those costs in your practice in the amounts that you charge your [380] patients?

A That is correct.

Q And have you had any courses in Accounting, for instance, in college or otherwise?

A I took a course in Basic Accounting in the mid-1970's, yes.

Q So, you are familiar with the principles of Basic Accounting?

A That is correct.

Q At least in a basic sense?

A That is right.

Q And you are familiar with those principles of accounting and the practice of accounting, at least as it applies to a physician's practice such as yours?

A I am familiar with those.

Q Now, once you learned that you would no longer be able to stay at the Rockford Memorial Hospital, which, I believe, was in February or so, did you speak to anyone about the costs of moving your space to another location, moving your practice to another location?

A Yes, I have.

Q And have you spoken with contractors and plumbing people and heating people and vendors, and the like, to see what it would cost?

A That is correct.

* * * * *

[382] BY MR. GILBERT: Q Now, you previously testified, Dr. Ragsdale, that those two exhibits you prepared to aid you in your testimony about the estimates of what the basic costs would be to move your practice to another location and to comply with the Ambulatory Surgical Treatment Center regulations, wasn't that your prior testimony?

A Yes.

Q Now, Dr. Ragsdale, why don't we go through these documents and explain to the Court your estimations of

the costs of moving your practice and the cost, that is, the extra cost that would be involved if you had to comply with all of the physical plant regulations of the Ambulatory Surgical Treatment Center Act.

Let's start with Plaintiffs' Exhibit 17. This is one of the documents that you prepared to aid you in your testimony, is that correct?

A That is correct.

Q Would you explain, overall, what this document covers.

A This document represents a summary of the costs that will be required to relocate my current practice in such a manner as I would deem appropriate for my needs and requirements to continue what I am doing right now.

Q So, the total at the bottom there, or the second line from the bottom, where it says "Total, $148,200," is that [383] the total cost that you have estimated?

A That is the total in this particular model and this is based upon actuality.

That is the total initial out-of-pocket expense that will be required, in addition to whatever value is attached to the basic leasehold space agreement.

In other words, for true accounting purposes, some value should be attached to the leasehold but I have, in addition to that—well, in addition to that it will require that I spend $148,200—

Q When you say "value to the leasehold," are you saying that you are going to have to pay rent?

A That is correct.

Q When you have a new place?

A That is right.

Q And the rent is not included in that figure?

A That is correct.

Q That is, in effect, the remodeling expense, the renovation costs?

A Correct. Exactly.

Q And those are costs that are being incurred because you are losing your lease at the Rockford Memorial Hospital building?

A That is correct.

Q And if you were to stay where you are now you wouldn't [384] be incurring these expenses, is that correct?

A No, I would not.

Q Now, at the bottom—

THE COURT: What is the top figure again? "Require 3,600 square feet base cost."

MR. GILBERT: Yes. I will have the witness—

BY MR. GILBERT: Q Why don't we go through and explain that.

A Yes. All right.

Q If you would explain that, Dr. Ragsdale.

A Certainly.

THE WITNESS: Your Honor, to provide the facility that I deem appropriate and applicable for my practice that we have been talking about here for the last several days, okay, it would—

THE COURT: Well, this is the rent for 3600 square feet?

THE WITNESS: That is the rent for 3600 square feet.

THE COURT: Okay.

THE WITNESS: I need 3,600 square feet to actually do, properly, what I am doing.

BY MR. GILBERT: Q That's without regard to the state requirements of the ASTC?

A Without regard to the state requirements. To do it right.

* * * * *

[390] * * * Q Okay. Now, your "experience"; why would patients be non-paying?

A Some of our patients simply can't afford to pay and we are a service organization and we provide a certain amount of free care.

Q And so you have got that as 3,300?
A That's per the 3,300.
Q And you divided the $74,100 a year by the 3,300 paying patients per year to reach the $22.45?
A That is correct.
Q So, does that constitute an additional expense that you are going to have to pass on to your patients as a result of your move, on top of the rate that you charge them now for your services?
A That additional expense will need to be covered in some fashion.
Q Do you have any other way of covering it other than the patient fees?
A There are only two ways to cover it, one is to increase patient fees and the other is to eat it.
Q Now, let's turn to Plaintiffs' Exhibit 18 for [391] identification.
A Okay.
Q Which is entitled at the top "Extra above basic cost"?
A That is right.
Q And what does this document that you have prepared constitute?
A Okay. This represents an estimate of what would be required, in addition to Exhibit 17, to bring my estimate of reasonable compliance with the ASTC regulations.
Q All right.
A In other words, when I say "my estimate of"—well, this is what I think probably I could get through the department based upon my discussions with their architectural staff.
Q You have had discussions with the architectural staff as to the physical plant requirements that would be necessary to meet the reg's and their opinion?
A That is right.

Q So, you are saying to meet their so-called "substantial compliance standards," this is what you would have to do?
A To meet each and every regulation would not be covered by this but to meet what I would probably be—I mean, what would be probably substantial compliance, and I am guessing, you know, but that is my estimate of what it would require, yes.
[392] Q I see. All right.
So, if you were to meet each and every regulation would it be more or less than the figure that is on Exhibit 18?
A It would be more than this figure.
Q All right. Let's go—well, first of all, at the bottom you say: "Total extra per year," and this is the second line from the bottom, is that right?
A That is correct.
Q And there is a figure there of $83,200"?
A That is correct.
Q And that is the figure that you concluded it would cost you to comply with the act as you think it has been interpreted by the department through the meetings that you have had with the department people?
A That is correct.
Q Okay. Well, let's go to the numbers here now.
Line 1, it says: "1,500 foot space at"—is that .005?
A Yes, but that's—
Q Should that also be $5.50?
A That should also be $5.50, yes.
Q $5.50—is that per foot?
A That's per foot.
Q Per square foot?
A Yes.

* * * * *

[400] * * * Q All right. And you have here, in the next column it says, or in the next line it says, "Total extra per you equals $83,200"?

A That is correct.
Q Is that right?
A That is right.
Q And that, I take it, is totaling up the $8,200 per year for the space, the rental, and the $47,250 per year for the remodeling and the $24,750 per year for the elevator, is that correct?
A That is correct.
Q Plus the three thousand operating cost?
A Correct.
Q And then the next line, or the final line, says: "At 3,300 pt," which I assume means "patient", is that correct?
A That is correct.
Q ". . . equals $25.21 per patient," is that right?
A That is correct.
[401] Q And that represents the extra expense if you were to pass it through to your patients that is a result of the ASTC regulations that you do not consider necessary, medically necessary, for your practice, is that right?
A That would have to be passed through, yes.
Q Are any of the expenses on this Plaintiffs' Exhibit 18 that you consider to be medically necessary for the practice in which you engage?
A No.
Q Are any of these expenses related to any types of physical plant facilities that would enhance your practice in any way?
A None.
Q Now, have you totaled up the extra patient cost from Exhibits 17 and 18?
A I did. I don't recall the number but I can add it up again for myself right now.
Q Okay. And what is the number?
A $47.66.

Q That would be per patient?
A Per patient.
Q Additional cost?
A That is correct.

* * * * *

[412] * * * Q Which means that you were not in compliance with that particular regulation?
A In 1982 we were definitely not in compliance and it was definitely a regulation.
Q And what is written to the right of that?
A At that time Mr. Jardine made a note stating "Nature of facility and operation actually does not require such a large room area."
Q As a result of that survey conducted by Mr. Jardine of the Department of Public Health in 1982, were you cited with a deficiency for not having a 250 square foot procedure room?
A No, we were not.
Q Did you continue to maintain your ASTC license after that?
A Yes.
Q Now, you mentioned previously that you had your 1985 meeting in March with Mr. Linder and Mr. Jardine?
A That is correct.
Q Is that correct, regarding the physical plant requirements?
A Yes.

* * * * *

[414] Q Okay. Now, I want to refer to an incident in which you were written up for a deficiency within the last six months, and maybe you can help me out with the day, for regarding the lack of a qualified medical technician or lab technician, I forget which it said.
A Yes.

Q I forget the exact term used.
A Yes. Right I believe that that was after a site visit in either June or early July of this year.
Q Now, did Mrs. Ramsay come to your site for one of her normal quarterly site visits at that time?
A That is correct.
Q And were you with Mrs. Ramsay when she was in your facility?
A Yes, I was.
Q And following her visit did you sit down with Mrs. Ramsay and did she review for you what she had found as a result of her survey of your facility?
A That is correct.
Q And what did she tell you at that time in terms of any deficiencies?
A At that time our previous laboratory technician had left for other employment and we were using a non-ASCP lab technician, with wide experience but no certification; nine years' experience but with no previous certification.
[415] Ms. Ramsay noted that this was a deficiency and that she would have to cite this on her report but indicated her personal opinion that this was a very minor affair; that as far as she was concerned a nurse or a reasonably qualified individual could do the lab report or reports or the laboratory work, that she was not at all concerned about this particular deficiency.
Q Did she mention to you when she said that she was not "at all concerned"—
A I am paraphrasing that, of course.
Q You are paraphrasing that but did she state to you that she thought that it was medically necessary or not medically necessary to have that particular type of lab technician?
A Without putting words into her mouth, the gist of it was that she did not feel that this was a medically necessary requirement, to have an ASCP lab technician.

Q But, yet, she still wrote up the deficiency?
A She is required to. It was a deficiency and she is required to write that up.
Q In your medical opinion, was it necessary for you to have a lab technician with the qualifications of the act?
I don't have the section in front of me but there is some particular organization that someone must belong to and must be certified by, and the like, and are you familiar with that provision?
[416] A Based upon—yes, I am familiar with that.
Based upon discussions with a consulting pathologist and my own direct observation, no, it is not medically necessary.
Q Now, despite Mrs. Ramsay telling you that she thought that it was a minor problem that really was not of substance and that you shouldn't be concerned about, you said she wrote it up.
A Yes.
Q What happened next with regard to that situation?
A Well, I don't recall the exact date but sometime in late August—or I believe it was early September, why, I received a letter from an individual, a director or some director in the Health Facilities Division, threatening revocation of our license.
Q Were you surprised when you received that letter?
A Yes, I was.
Q Why were you surprised?
A It seemed like a pretty dramatic response to a very, very minor discrepancy of the sort that the department had been dealing with almost informally for 12 previous years.
Q Now, Dr. Ragsdale, in view of those couple of examples that you have just given and in view of some of your other testimony that you have given before about the vagueness of the act and how you are not quite sure how

you can comply with [417] the act, what have you had to do as a result of this?

What have you had to do as a result of different people in the department giving you different views on what is in compliance and what have you had to do as a result of the department not informing you as to when and when they are not enforcing various provisions of the act?

Has that affected you in your medical practice?

A Yes, it has.

Q How has it affected you in your medical practice?

A The direct effect is that regardless of interpretation, the operator or the physician, me, must be at all times in compliance, period, regardless of what anybody may have said they will accept or you risk revocation of your ASTC license and your medical license.

Q How can you lose your medical license as a result of that?

A Well, through the Medical Practice Act, since if your ASTC license is in violation, it is no longer an ASTC and you are now doing abortions in a place other than an ASTC. It is a complicated chain but that's how it comes about.

Q So, in addition to having the risk of losing your license, and you talked about the costs here of complying with the act and the difficulties that you have talked about or that you have discussed about meeting the Certificate of Need requirements and the fact that you have lost your lease, what do you face in the near future if you don't get the [418] injunction that you are seeking here today?

A Well, I think that there are two questions, and may you want to ask them separately, but the first question is what I will face, and what I will face is the inability to continue the practice which I am currently engaged in, that is, providing abortion services in Northwest Illinois.

Q And that will occur—

A It will occur on December 31, 1985.

Q What is that going to do to your patients?

A Well, that's the second question, as to what that will do to my patients and what that will basically mean is that there will be no abortion availability, for practical purposes, in the northwest area of the State of Illinois. If you start from the City of Chicago and if you go north to the state line, west to the Mississippi River and south to Peoria, within that geographic area there will be no abortion availability in Illinois.

Now, this will mean—

Q All right. Okay. Now, as a result of that, what will happen to your patients?

A Okay. Those patients within that area will, first of all, face the emotional and, if I may say, the burden, of having to try and find a medical facility outside of their area, okay? And this can be very difficult, both emotionally and in actual practice, for people to do.

[419] Q Can you give the Court some more concrete reasons why that is difficult.

A All right.

Q And what it does.

A Okay. I am not sure if I know where your question is leading, exactly, and so I will—or perhaps you could break it down.

Q Well, all right. Fine.

Maybe I should rephrase it. I mean, what is—well, you say that it is going to affect your patients emotionally and, I mean, is there a possibility of any medical effect upon them as well?

And why don't you tell the Court what effect it will have; I mean, what is going to happen to that patient out there right now who is referred by her doctor to Dr. Ragsdale, or your own patients right now who come to you?

A Okay. All right. Well, the first thing that will happen to that patient is that neither she nor, in many cases, her referring physician, will know where she should go for a medically safe abortion. This information—we have been providing this for 12 years. Okay.

Her doctor isn't going to know because he has been referring to us. She will be on her own to find some other source of available care. It is there but it will require some work and it will place a burden on the individual.

[420] Q You say that it is there; is it there in Northwest Illinois?

A It is not there in Northwest Illinois.

Q It is there in Chicago, perhaps?

A It is "there" somewhere else. Okay.

Q Maybe in Madison, Wisconsin?

A That is right.

The second thing that the patient will have to do is that she will have to travel some considerable distance to obtain this care. She will incur the expense of, simply, travel, and possibly that of added time off from work as a result of this.

Q And, medically, what effect can it have on a woman, traveling to have an abortion?

A Okay. Certainly the less distance that the woman is required to travel, either to have or after the abortion, on her return home, why, the better this is for her, medically.

Q Why is that?

A Okay. All right. It is simply a matter of—well, even though it is a minor surgical procedure, it is better not to have—first of all, even though it is a minor surgical procedure, it is better, and the less you have to travel the better, and the less you have to travel the better that it is, medically.

[421] Okay. Secondly, the greater the distance is that the patient—well, the greater the distance the patient is from her source of care, if she has a problem following her abortion and if she needs additional medical attention, if she has now had to leave her normal medical care area and has had to go somewhere else, go somewhere else, come back, she will experience very definite problems medically in finding the necessary care, should she need it, after the abortion. This will be much more difficult for her to obtain. It may be less readily available. And it is possible that there could be very definite medical problems that might be difficult to treat in the circumstance.

Q What about the emotional effect on the patients?

A Well, it is hard to quantify emotional effects, but, certainly, the process that I have just described will have an adverse emotional impact on this patient.

* * * * *

[423] THE COURT: Are you going to have any more testimony as to the emotional effect? I sort of cut that short and I didn't mean to do that.

MR. GILBERT: We have another—

THE COURT: I mean, the uncertainty of a possible source and the delay, and all of the other factors?

MR. GILBERT: We have another witness who will be testifying specifically concerning those matters.

THE COURT: I see. All right. Fine.

Well, I didn't mean to cut the testimony off.

MR. GILBERT: No, no.

Well, let me ask:

BY MR. GILBERT: Q Do you have any more testimony about that or on that subject that you would like to give, Dr. Ragsdale?

A As far as the emotional impact goes, I think—well, yes, one of the most important aspects, since patients are referred for abortion care, and in my direct observation of

abortion patients, I can state that it is extremely emotionally supportive and comforting to a woman when her physician is able to say to her, "I want you to go to "this doctor or that doctor, in order to have your abortion. I have known him for ten years," or whatever, "and he will do a good job for you," okay.

This adds a great deal of quality to the patient's [424] care. And the loss of this in an otherwise emotionally stressful situation, would be definitely detrimental and harmful to the patient. And I know that of my own personal experience.

Q Now, one other element of this is the delay, as I understand, and you mentioned before that one of the factors that is involved in the safety of the abortion procedure is the length of gestation, is that correct?

A That is correct.

Q Now, do you think that the delay in being able to, number one, find someone who can perform an abortion and, number two, traveling to that physician, particularly if you are no longer able to practice, can affect the actual safety of the procedure?

A There will be delay in two ways: First of all, there will be patients, as I stated, who will have difficulty—who will simply have difficulty in finding an alternative source of care and this will create delay. Okay.

Secondly, there will be, for some, total delay, in the sense that we do provide services below cost or even for free to a certain group of patients and these patients will have nowhere else to go for this service.

Q Because they wouldn't be able to pay for it?

A Because they will not be able to pay for it. That is right.

[425] So, for them the delay would be complete.

Q Also, Dr. Ragsdale, with regard to early second trimester abortions, do you know if those are performed in all of the other abortion facilities in the State of Illinois?

A There is a limited number of facilities that are performing early second trimester abortions in Illinois at the present time and I would not wish—well, no, there is simply a limited number of facilities.

We are one of a relative few who provide this service.

Q So, would it be accurate to say that for women who are either actually approaching or in the second trimester, at least the early part of their second trimester, that it will be that much more difficult and even more difficult for them to obtain abortion services?

A Yes, that is very definitely true.

Q That is, if your facility should close?

A Yes.

* * * * *

Cross-Examination

* * * * *

[510] A Well, would you like a general—okay.

I would agree wholeheartedly with Dr. Hern's testimony of several days ago that after any abortion the tissue obtained at the time should be examined by an individual with experience in this field.

The pathology report referred to here, you have to refer back to some other sessions but the pathology report referred to here is one provided by a consultant or consulting pathologist.

In many cases there really is no particular purpose to that pathology report other than confirming what has already been obtained.

In very early pregnancy, there may be some value in terms of actually confirming the pregnancy in the tissue that was removed from the uterus.

So, the answer to your question is—is probably as vague as the answer I have just given.

Q But one of the purposes would be to confirm pregnancy?
A That is true.

* * * * *

[514] Q And a list of various items underneath that?
A That is correct.
Q And there is a "$98,000" figure to the right of that list?
A That is correct.
Q Now, that number was provided to you by a contractor, wasn't it?
A That's correct.
Q You were told that number by a contractor?
A Yes, I was.
Q Similarly, there is a list of other items beginning with "Floor" and ending with "Moving" under the "Remodeling Expense" items, is that correct?
A Yes.
Q And the various estimates, or numbers, rather, the various numbers that are set out here on this exhibit also came from what you have been told by certain other vendors?
A Yes.
Q Okay. Turn to 18, Plaintiffs' Exhibit 18, please.
A Yes.
Q Do I understand correctly that your current fee for abortion services is $250?
A That is correct.
Q And you collect that fee from approximately 3,300 individuals per year?
[515] A That is the estimate that we have used in the past.
Q Now look at the estimates under Line 2 of Plaintiffs' Exhibit 18. Is there any "Remodeling"?
A Yes.

Q All of those figures there were provided to you by either a contractor or a plumber or an architect or some other person?
A That is correct.
Q Those individuals told you what those estimates were to be?
A That is correct.
Q Now, you have included as the third item there an elevator?
A That is correct.
Q Okay. Would you turn in Plaintiffs' Exhibit 10, Regulation 205.1320—
A Yes.
Q And would you take a look at Subpart (d).
A Subpart which?
Q (d), as in dog.
A Yes. I'm looking at Subpart (d).
Q All right. Now, is it your opinion that it is not medically necessary for you to perform a first or early second trimester abortion if your facility is not accessible to the physically handicapped?
[516] MR. GILBERT: I object. That sounds to me more like a question of law, and, if not, I don't understand what the question is.
BY THE WITNESS: A Would you define—I am sorry.
MR. GILBERT: Just a moment.
THE COURT: Yes. I am not sure either.
Why don't you rephrase the question.
I am going to let you ask about general subject matter of this but I am not quite sure what the thrust of the question was.
BY MR. FLAHAVEN: Q Well, Doctor, look at Subsection (d) there.
A Yes.

Q Is that requirement medically necessary for the performance of a first or early second trimester abortion?
A For purposes of medical necessity, would you define "accessibility" and would you define "physically handicapped."
Q Well, let's say that it is someone who needs to use an elevator.
A I would like to know—that has not—you have described a means of access; I would like to know what you mean by "accessibility" and what you mean by "handicapped."
Q Well, by "accessibility" I mean the ability to use an [517] elevator and by "physically handicapped" I mean someone whose handicap is such that they are required to use an elevator to have access.
A I know of no individual under any circumstances who is required—for whose transport from one floor to another, an elevator is required.
Q You know of no handicapped person or condition—
A That's not what I said.
Q Well, then let me finish the question.

You don't know of a handicap condition such that—which would require an elevator for transport from one floor to another?
A I know of no handicap condition that would require an elevator to permit transport of one individual, or of an individual, from one floor to another.
Q They should walk up and down the stairs?
A I did not say that.
Q They shouldn't drive from one place to another because that might be dangerous to their health?
A No, they should not.
Q But they shouldn't be transported upstairs? That is not dangerous to their health, is that correct?
A There is a variety of mechanisms for transport from one floor to another floor. An elevator is one such mechanism. I know of no handicap that requires an elevator [518] for transport from one floor to another.

Q Look back at Plaintiffs' Exhibit 18.
A Yes.
Q Under the cost estimate you frame, isn't it true that—and under the method you have for repayment of debt, that your remodeling expense, or debt, rather, will be retired after two years?
A The model that is employed here would imply that, yes.
Q So, then, the costs which you would have to pass along to your clients, your patients, or that you would have to absorb yourself, would be reduced after two years, wouldn't it?
A Under this model, that's the case.
Q Is it necessary for you to recoup that remodeling expense from your patients within a two year period?
A Yes.
Q You couldn't spread it out over more years than that?
A The model I have presented here is the model as it will actually or would actually be required of me, to the best of my knowledge.

* * * * *

[521] Q Doctor, you testified as to your qualifications, training and experience in performing abortions over the past, is it three days now?
A That I have been testifying?
Q Yes.
A Yes. I have been testifying, yes.
Q In your opinion, Doctor, do all physicians licensed under the Illinois Medical Practice Act have the qualifications, training and experience to perform safe first and early second trimester abortions?
A No, as stated.

Q As stated?
A Right.

* * * * *

Redirect Examination

BY MR. GILBERT: Q Dr. Ragsdale, in the cross-examination you were asked a question about whether any court proceeding has ever been instituted against you with regard to failure to comply with the Ambulatory Surgical Treatment Center Act.

Have there been any administrative proceedings, that is, enforcement proceedings, undertaken by the Department of Public Health or any other state agency with regard to those matters?
[522] A Yes.
Q What type of proceedings?
A These proceedings were undertaken by the Department of Public Health subsequent to architectural inspections in 1982 and '83. They related to, as best as I can determine, the requirement for the facility to be identifiably separate; that is, if I can try to explain it better, in our medical building the offices all have panels so that they transmit some light inward from the hall. This is not fire-rated and it was the department's insistence that we take out our light transmitting panels and put in one hour rated wallboard to make our facility a separate fire box and wall it off from everything else in the building.

As a part of this and some delay in doing this we got involved in an administrative hearing.
Q The other physicians' offices in the—there are other physicians' offices in that building?
A Yes, there are four floors of physicians' offices.
Q Do they have those light transmitting walls that you just testified about?
A Yes, they do.

Q Has the state ever forced them to comply with any kind of requirement that they be made into separate fire boxes?
A No.
Q There remain physicians practicing in offices that [523] have those separate light transmitting walls?
A Yes.
Q Okay. The other thing that you were—by the way, whatever happened in that enforcement proceedings?
A Once the work was completed and after a considerable exchange of letters, and so on, the proceeding was dropped. Or was dismissed, whatever the appropriate legal term is.

I might add, during that time our license was held in suspension until this was completed.
Q Now, you also were asked questions about Section 205:1320 requiring access to handicapped persons—
A Yes.
Q —in ambulatory surgical treatment centers?
A Yes.
Q And you mentioned that it was not necessary to have an elevator?
A That is correct.
Q An elevator to transport people?
A Correct.
Q Will you explain your answer a little more.
A Sure.

First, the number of handicapped who use our facility is less than, significantly less than one percent, and probably as low as one-tenth of one percent.

The patients whom we serve are young, healthy, [524] ambulatory, by definition, people. So, in terms of access, the public we serve is a non-handicapped public.
Q What about transporting the handicapped between floors?

A Secondly, the egress—they egress the same way.

Now, should the need arise to transport a handicap between floors there is certainly, on the rare occasions that it is necessary, there is certainly no difficulty in getting someone from one floor to another. This is a common situation.

Q How is it done?

A By carrying them.

Q Have you ever done that?

A Yes.

Q With regard to patients?

A Yes.

Q When that was done were there any medical complications as a result of doing that?

A None whatsoever.

Q Having practiced medicine in the State of Illinois as a private physician, do you know if a doctor's office is required to have an elevator if it happens to be on a second or third floor?

A I know very specifically that a physician's office is not required to have an elevator.

Q Do you know of physicians' offices without elevators [525] that happen to be on the second or third floor?

A Yes, I do.

Q In the City of Rockford?

A In the City of Rockford.

* * * * *

[611] * * * MR. FLAHAVEN: All right. And 17 and 18—

THE COURT: 17 and 18 now.

MR. FLAHAVEN: Yes. 17 and 18 are those cost estimates.

[612] THE COURT: Right.

MR. FLAHAVEN: And we have hearsay objections to both and with respect to all of the numbers, the figures, that were told to the plaintiff by these various contractors.

THE COURT: Well, it seems to me, again, that those are verbal acts. That really isn't the sort of hearsay that the hearsay exception deals with. There probably may be a more specific exception but, essentially, what he is testifying to is that that is what he was told by these various contractors and it is indicating, in effect, the verbal act of making a contract. That is what they would charge to do the work. It is not as though they—as though it is being admitted for the truth of the matter as to what it would actually cost, the contractor, or anything else that might be involved.

And, to that extent, it really isn't hearsay. It is not being used as a statement—let me get the language of it here.

All right. That's 803—

MR. GILBERT: Right.

THE COURT: "Hearsay involves a statement that is an oral or written assertion if it is intended by him as an assertion."

This is similar to testifying as to what an oral contract is but what this is, in effect, is a tentative oral [613] contract between the plaintiff and each of these trades as to what they would charge to do a certain amount of work and it seems to me that that isn't what is covered either by the definition of hearsay or is barred by the hearsay rule.

It seems to me that it is—and the other part of it would be that, although I don't believe that the testimony was that precise, that it might also fit within the Business Record Exception of the hearsay rule, if those figures had been noted down in business records by the plaintiff.

But, in any event, it seems to me that, just as contracts, statements that lead up to or constitute the making of a contract, and the like, are admissible in evidence, so should this be admissible in evidence.

Certainly, the witness was present and subject to cross-examination with respect to this.

Again, it is not necessary to cross-examine the reason for the underlying figures that's not the issue here; the issue is the figures, the actual cost of what it would cost and the witness testified as to what the contract with the various trades would require, I mean, in order to do that, and he was subject to cross-examination with respect to that.

So, on that basis, I will overrule the objection and admit into evidence Plaintiffs' Exhibits 17 and 18.

(Plaintiffs' Exhibits 17 and 18 received.)

* * * * *

TRIAL TESTIMONY OF JOHN A. BARTON, M.D.

Direct Examination

[455][1] BY MS. KREISEL:

Q Doctor, is it your opinion that there is a medical necessity for the regulation by the state of out-patient surgical facilities?

A Yes, I do.

Q Why is that?

A To provide safeguards for the citizens of the state and where the operations are performed have some standards to which they must adhere.

MR. GILBERT: Your Honor, I move to strike that last answer. I thing that that is, again, in the realm of irrelevance and immateriality about—it is a legal question as to whether the state should be regulating or not.

He can speak to the medical necessity of particular regulations—

THE COURT: Well, that was the question and I will overrule the objection and permit the answer to stand.

You can go further into it on cross-examination.

BY MR. KREISEL:

Q And in your opinion, Doctor, what safety factors would be furthered by such regulations?

MR. GILBERT: I am going to object. ". . . such regulations" is so vague.

I think that we need to talk about some particulars here.

[456] The idea of regulating the practice of medicine is something that is not an issue in this case. ". . . such regulations" could mean anything.

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[1] Numbers in brackets refer to the Court Reporter's original pagination of the Transcript of Proceedings.

THE COURT: All right. I don't—I am going to overrule the objection. I will permit you to ask the question they way you wish and I will let counsel cross-examine to sharpen up anything that he wishes.

BY MS. KREISEL:

Q Doctor, in your opinion, what safety factors would be enhanced by regulation of out-patient surgical facilities?

A I really wouldn't deal to the specifics of the brick and mortar building code issues. I hold no expertise in that.

I feel that regulations that require a monitoring system, staffing, equipment, cleanliness, these are the issues that would affect, directly affect, medical safety.

However, if you are asking me what codes I would write, I am not prepared to do that.

Q I understand.

Do you have an opinion as to whether the threat of discipline imposed by the Medical Practice Act insures the safety of patients in Illinois who go to out-patient surgical facilities?

MR. GILBERT: I am going to object again. That's not a medical question. This person's expertise is as to the medical matters involved.

[457] MS. KREISEL: I think that their witnesses have been talking about that, Judge.

THE COURT: Well, I am going to sustain the objection on the basis of a lack of foundation. There has been no indication at all that he is familiar at all with this area. He operates out of a very famous hospital and that seems to me to not indicate any particular knowledge as to the facilities—a facility like Dr. Ragsdale's facility. And if he doesn't know about such facilities I don't know how he would have a foundation to answer such a question.

BY MR. KREISEL:

Q Doctor, are you familiar with ambulatory surgical treatment centers?

A Yes, I am.

Q Are you familiar with Dr. Ragsdale's facility, for example?

A No, I am not.

Q Okay. Does—

THE COURT: You might indicate what his familiarity is because there are ranges of familiarity.

MS. KREISEL: Yes.

BY MS. KREISEL:

Q To what extent are you familiar with ambulatory surgical treatment centers?

A In the State of Illinois?

[458] Q Yes.

A I know of their existence. I have never operated in an ambulatory surgical center, free standing.

Q All right. Have you done so in other states?

A Other states and other countries, but I am not sure exactly what title they might have held.

Q Okay. So, were they out-patient surgical facilities?

A On some of the Indian hospitals and reservations where I have worked as a volunteer there was a surgical facility unconnected with the hospital but I am not quite clear if that is a true definition of an "ambulatory surgical center," and that is why I am struggling with the question.

Q Was that facility primarily devoted to surgical procedures?

A Yes.

Q And how familiar are you with that facility?

A Well, I have worked at several in the Southwest. I would find it difficult to compare it to any facility here in a developed city, however.

Q Why is that?

A They are rather crude and it is a rather hostile environment in which they function in Fort Defiance, Arizona,

for example. We rather made do with what we had. I would not at all call it optimal.

* * * * *

[462] * * * Q Are you also familiar with possible complications resulting from diagnostic D&C procedures?
A If that stands for dilatation and curettage, yes, I am.
Q Yes.
A Yes.
Q And are you familiar with possible complications resulting from abortion procedures?
A Yes, I am.
Q Are there any similarities between the complications which can result from those three procedures? Are there any similarities?
A It is first well to remember that all three apply to the same basic organ, the female uterus, and, consequently, complications are going to be similar, and all involve using some instrumentation within the cavity of that organ. Therefore, the complications are quite similar in all three procedures and basically they are that of perforation of that organ, hemorrhage resulting from interfering with the blood supply to that organ or infection, either from introducing it at the time of the procedure or operation or in a post-operative complication. These are the three basic major complications associated with all three.
Q Are there any differences between the complications in those procedures?
[463] A Yes. Having said that, that the basic complications are similar, the quality of those complications are much more serious and profound in the abortion than they are in the diagnostic dilatation and curettage and/or the insertion of intrauterine devices.
Q And why is that?

A "Hemorrhage" is a broad, general term. If you have a nose bleed it is a hemorrhage. It is a much different matter in severity if you sever a jugular vein, but that, too, is a hemorrhage. But, quantitatively, they are a world apart.

The same is true with the bleeding that is associated with the hemorrhage involving a complication of abortion as opposed to the hemorrhage encountered with a diagnostic dilatation and curettage or the insertion of an intrauterine device.

The same is true with relation to infection. The incidence of that is much higher associated with abortion than that associated with procedures of intrauterine device or a diagnostic D&C.
Q Why is that?
A Well, principally, the organ in which you are performing the procedure or operation is in a different state in pregnancy. It is larger, it is filled with products of conception, which have implanted themselves into the wall of that organ; it is softer due to the hormonal changes of [464] the pregnancy, which lends more readily to perforation, and it is more vascular; its blood supply is much more developed and so hemorrhage can be much more severe.
Q Is the insertion of an IUD considered to be a surgical procedure?
A It is classified as a procedure. I will not say whether it is medical or surgical. But they are done most principally, for example, in our federally-funded Family Planning clinics by nurse-practitioners and/or family practice physicians.

Some would call it a "medical procedure" rather than a "surgical procedure."

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[466] * * * *Cross-Examination*

BY MR. GILBERT:

Q Dr. Barton, do you agree that there is no medical reason to single out abortion for regulation as opposed to any other surgical or medical procedure?

A In terms of any operation, no, there is no reason.

Q And are you familiar with any other regulations in the State of Illinois, or any regulations in the State of Illinois, that regulate specifically or mention any particular operation or surgical procedure?

A Not in relation to the operation itself. There are federal regulations, for example, that control sterilization, things of that nature.

Q But, in Illinois and under Illinois laws, apart from some federal regulations on sterilization, you are not familiar with any regulations that single out any procedure for particular regulation or state that they should be performed under any particular circumstances or anything of that sort?

A Not to my knowledge.

[467] Q Now, abortions, first trimester and early second trimester abortions, are minor procedures, aren't they?

A They are classified as minor surgical procedures, yes.

Q And diagnostic D&C's or dilatation and curettage procedures are also in the same category, as "minor surgical procedures," isn't that right?

A Yes.

Q And isn't it true that one of the reasons that those are characterized as minor medical procedures or surgical procedures, as you will, is that the risk of complication from those procedures is relatively low?

A Your terminology of a "minor surgical procedure" vis-a-vis a minor medical procedure—they are minor operations; they are not within the range of procedure, they are operations.

Q But as operations they are minor?

A They are considered in that category, yes.

Q And "minor" at least in the respect that the risks from such operations are minor compared to other operations?

A That is one of the considerations, yes.

Q Indeed, isn't it true that the risk of death, for instance, from an abortion is extremely low?

A Certainly, done under appropriate circumstances. Yes.

Q By the way, are you familiar with the CDC, Center for Disease Control, which I believe is in Atlanta? You have heard of that body?

[468] A Yes.

Q And that is a federal organization that is associated or is involved in public health studies and reports, is it not?

A They are the organization charged by the federal agencies with monitoring abortion, yes.

Q And are you familiar with the studies of Mr. Grimes and Mr. Cates and others of that organization of the CDC with regard to risks in abortions?

A Yes. I have read the reports, or some of the reports, published under the names of Grimes and Cates, yes.

Q And isn't it true that those reports conclude that, number one, the complication rates for abortion, at least first trimester and early second trimester abortions, are very low?

A That is a correct statement. Yes.

Q And isn't it also true that those studies have found that the complication rates and the risks of abortions performed in out-patient facilities are no greater than the risks and complication rates of abortion rates performed in hospitals?

A Of those reported to CDC that would be correct.

Q And those studies are nationally recognized in the obstetrical and gynecological field, aren't they?
A That is a correct statement.

* * * * *

[470] * * * BY MR. GILBERT:
Q So, the best scientific evidence that we have right now is the Grimes and Cates study or are the Grimes and Cates study, would you agree with me on that?
A They give us a history of what has happened, yes.
Q So, you will agree that they are the best that we have?
A Yes. Yes, they are the most comprehensive.
Q Now, in terms of the complication rate for abortion, particularly first trimester and early second trimester abortions, you would agree, and I believe you actually testified to it, and maybe I am confusing your deposition testimony to your testimony here today, but would you agree that the skill of the physician is the most important factor in determining the risk of complications in first and early second trimester abortions?
[471] A If I have not said that, yes, I would agree that that is true.
Q And in considering that and in connection with other factors, that's overwhelmingly the most important factor, wouldn't you agree?
A I would agree.
Q And have you reviewed the Ambulatory Surgical Treatment Center regulations and the act in connection with—
A To some extent. It was furnished to me; I don't have a line-by-line familiarity with the document.
Q Well, let me show you Plaintiffs' Exhibit 10, which is the Ambulatory Surgical Treatment Center Act and Regulations.
A Yes.

Q If I may hand that to you.
A All right.
Q Now, from your review of that act, do you know of any provisions in the act that regulate the skill of the physician or surgeon performing the abortion, or performing any surgical procedure covered by the act?
A Not to my knowledge.
I don't believe that this document was designed to test the skill of an individual surgeon.
Q So, in the same sense, and you were talking before about how the Medical Practice Act really doesn't provide a safeguard in and of itself for patients in the State of [472] Illinois because it does not govern the skill and the ability of the particular physician—is that an accurate characterization of your prior testimony?
A I believe it is, yes.
Q Would you agree with me that the Ambulatory Surgical Treatment Center Act has the same deficiency that you pointed out in the Medical Practice Act?
A If the question is does this control quality or capabilities of a surgeon, is that—
Q Yes.
A No, it does not.

* * * * *

[474] Q So, do you think that this provision is medically necessary to improve the safety of first trimester and early second trimester abortions, indeed, of any abortion?
A I really would not have any comment on that pro or con. I don't—I am reading one paragraph from the entire licensure provision and, as a surgeon, I don't understand what it could do to lend credibility to the surgical procedure performed within the center, no.
Q But you would agree with me that under this provision a facility where abortions are performed could be run

by a psychiatrist who has never in his life performed an abortion or would, in your opinion, be qualified to perform an abortion?
A That is true by the wording of this section that you have referred to, yes.
[475] Q And you would agree that a psychiatrist of that type would have to under this provision—could, under this provision, actively be engaged in the performance of abortions at a center of that sort?
A By the document that you presented to me, that is, perhaps, true.
Q Let's turn to 205.750—well, no, I am sorry, let me change that. I meant to say 205.540.
THE COURT: 540?
MR. GILBERT: 540.
BY MR. GILBERT:
Q And Subpart (a), Doctor.
A All right.
Q Under "Postoperative Care," and I will represent that this is a provision that applies across the board to all ambulatory surgical treatment centers not just those in which abortions are performed.

Now, that reads, in Subpart (a): "Patients who have had general anesthesia, local anesthesia with sedation or a pregnancy termination shall be observed in the facility for a period of time sufficient to insure that no immediate postoperative complications are present."

Can you think of any medical reason why a provision of this sort should mention all types of procedures, operations involving certain types of anesthesia and then single out [476] pregnancy termination?
A That section is consistent with a minimal standard of good surgical treatment, whether it be an operation for pregnancy termination or any operation.

Q So, any competent physician should follow a standard of that sort?
A As a minimum.
Q As a minimum?
A Yes. Right.

It is my profession that one hour is too short a time.
Q But can you see any reason why pregnancy termination is specifically spelled out there?
A No, I cannot, unless it were a pregnancy termination that were done without any form of sedation, local anesthesia or general anesthesia.
Q But, in your experience, most pregnancy terminations are performed at least with local anesthesia, are they not?
A That is correct.
Q And pregnancy terminations are the only procedure listed here performed under local anesthesia without sedation, isn't that correct?
A Are you asking me what anesthetic is used in a pregnancy termination?
Q No, I am asking you to look at this section. Do you [477] agree with me that there is no other surgical procedure listed—
A That is correct.
Q —in which there is just a local anesthetic used?
A That is correct.
Q However, there are other surgical procedures in which local anesthetics are used, are there not?
A That is true.
Q And isn't it good medical practice for at least certain of those procedures that a patient be observed for an hour after the operations?
A Absolutely.
Q I mean, perhaps one of those would be a D&C and would it be your professional judgment that if a local anesthetic such as a pericervical block were used in a

diagnostic D&C, that the patient should be observed for an hour after that?
A As a minimum, yes.
Q Indeed, for a D&C, a diagnostic D&C, the same local anesthetic is used as for a first trimester abortion, isn't that correct?
A Dilatation and curettage?
Q Dilatation and curettage, yes.
A The same principles of anesthesia could apply.

* * * * *

[484] * * * Q Between 12 and 20?
A Yes.
Q Okay. But you do very few first trimester abortions?
A Indeed, the department as a department does not offer a separate clinic for those abortions, yes. Correct.
Q But, as to you, you personally do not perform any at all?
A Very few.
Q Indeed, maybe three to five a year over the last several years?
A Very few.
Q And you are, by no means, an expert in first trimester abortions?
A I don't know what an "expert"—that is not a field of my greatest interest, let me put it that way.
Q And you don't keep up with the literature on first trimester abortions?
A No. My general reviews of the literature are other than that.
Q In general, do you mean just the major medical journals that go across the board?
A Right.
Q And AMA Journal or—
[485] A Or our journals in our specialty. That is correct.

Q The New England Medical Journal, publications like that?
A Yes.
Q In fact, your sub-specialty is in gynecological pathology, is that right?
A Pathology and oncology.
Q And oncology?
A Yes.
Q Which is cancer of the—
A Yes.
Q Cancer in women's reproductive organs?
A Right. Yes.
Q And that is not an area that involves abortion practices except maybe—
A No. That is right.
Q —except maybe in some rare instance?
A No. That is right.
Q And, also, the abortions that you perform are performed, oh, 90 percent of them or so are performed under general anesthetic, is that correct?
A Yes, by far the greatest percentage. Yes.
Q And your late second trimester abortions, speaking of your 16 to 20 week abortions, there you use an installation method, is that right?
A Intra-amniotic installation, yes.
[486] Q And that is a method where you, in effect, induce labor through installing some type of fluid into the amniotic sac?
A Essentially, yes.
Q And the fluid that you use is prostoglanin and urea?
A As the medication, yes.
Q The medication that is inserted into the sac?
A Yes.

Q And the early second trimester abortions that you perform, the ones that are performed between 12 and 16 weeks, you use the D&E method, is that right?
A The dilatation and evacuation method, yes.
Q Dilatation and evacuation?
A Yes. As a method.
Q And you do those in a hospital operating room?
A Yes.
Q That is the same operating room that is used for major gynecological surgery?
A Yes.
Q And they are all performed under general anesthetic?
A Yes, with rare exceptions.
Q And even some of your first trimester abortions, of the few that you do, are performed under general anesthetic, is that right?
A Yes.
[487] Q Indeed, maybe 90 percent of them?
A Certainly a very large, a very high percentage. Yes.
Q Now, Doctor—

MR. GILBERT: One moment, your Honor, if I may.

(Brief interruption.)

BY MR. GILBERT:
Q Now, I believe you testified, Dr. Barton, that—Dr. Barton?
A Yes. Excuse me.
Q You disappeared there.
A I beg your pardon. I was leaning over to get some water here.
Q Now, since you have become an administrator and an academic in the last 15 years, the abortion field has changed greatly, hasn't it, since 1970?
A Well, certainly the laws governing the operative procedure have changed, yes.

Q And they changed at the point, in 1973, with the Rowe vs. Wade case, which you are aware of, is that right?
A Yes.
Q You are aware of that?
A Yes.
Q And you did go to law school, isn't that correct?
A Yes, but before Rowe vs. Wade.

* * * * *

TRIAL TESTIMONY OF WARREN M. HERN, M.D.

Direct Examination

[237][1] Q Why do you use a local anesthetic rather than a general anesthetic for first trimester or early second trimester abortions, Dr. Hern?
A Principally because it is much safer and a general anesthetic is not necessary.
Q When you say "safer," why is a local anesthetic safer, Dr. Hern?
A There is a number of reasons why it is safer: First of all, if you put someone to sleep there is a risk that they will not wake up even if you do nothing else to them and the risk of that is perhaps one in 20,000 or one to 10,000, which is a very considerable risk of death.

If you put a woman to sleep to do an abortion you add immeasurably to the risk—well, not "immeasurably" but in fact you do add measurably to the risk of the procedure itself and to the risk of death.
Q In what ways do you add to the risk of the procedure, Dr. Hern?
A Well, some anesthetic agents, general anesthetic agents, will cause the uterus to relax and to make it softer. That increases the risk of perforation of the uterus and it makes it more difficult to empty the uterus.
Q Why does it increase the risk of perforation, Dr. Hern?
A If the uterus—well, the uterus is a muscle and if it [238] is firm and has good tone then it is more resistant to perforation from a rigid instrument.

[1] Numbers in brackets refer to the Court Reporter's original pagination of the Transcript of Proceedings.

If it is relaxed and soft—in fact, under general anesthetic, under some conditions, it may be as soft as a wet paper sack. Then it is very easy to perforate the uterus.
Q So you would recommend using a local rather than a general anesthetic—
A Yes.
Q —in performing a first or early second trimester abortion?
A Yes.

If I may add, the risk of complications, major complications, with general anesthesia, it is many times greater than that of the risk of major complications with local anesthesia and the risk of death is two to four times greater.
Q Dr. Hern, what is the basis for your conclusion that the risks of both complication and death are greater for an abortion done under a general as opposed to a local anesthetic?
A Well, my own experience with general anesthesia in abortions is very limited. On the other hand, I have read the works of my colleagues who have studied this in some detail, particularly Drs. Grimes and Kates, and it is very clear from the statistics that there is a much greater risk with [239] general anesthesia.
Q Now, Doctor, just a couple of quick questions about a first or early second trimester abortion: Does this procedure involve any incision in the woman's body?
A No.
Q Does it involve any stitches or sutures?
A No.
Q Does it involve the administration of post-operative drugs as a usual matter?
A It may, yes.
Q Commonly, frequently?

A Well, I would say there are certain drugs that we frequently give post-abortion that cause the uterus to contract, yes.
Q All right. Dr. Hern, you just discussed certain complications pertaining to abortion, namely, the risk of perforation and hemorrhaging; how often do these complications actually occur during the course of a first or early second trimester abortion performed under local anesthesia?
A Well, it depends a little bit on the institution and the skill of the physician. Nationally, I think that, for instance, the risk of a perforation of the uterus in first trimester is approximately one per one thousand procedures.

I have never had a perforation of a uterus in my practice in the first trimester.
[240] But, on the other hand, it is a known complication of abortion.
Q Is this a major complication, perforation?
A Not necessarily. A perforation may occur and no other treatment may be necessary, depending upon the stage of the operation at which the perforation occurs.

On the other hand, perforation can lead to very serious consequences.
Q Dr. Hern, what about hemorrhaging? How often does a woman undergoing a first or early second trimester abortion under local anesthesia have hemorrhaging?
A I would say that in first trimester abortion and early second trimester abortion that hemorrhage is exceedingly rare and I would say that the "hemorrhage" definition that I would use would be blood loss excessive of 500cc's or about one unit of blood.

That has not occurred in my practice.
Q Do you have any idea what the national statistics are on hemorrhaging for first and early second trimester abortions? Is this a problem in the abortion services area?

A Well, I believe, again, that, nationally, this may occur one to two times per one thousand procedures. That would be my estimate.
Q Doctor, do you have any idea as to the statistics comparing the safety of a first trimester abortion with a full [241] term delivery, delivery after a full term pregnancy, are?
A Yes.
Q Can you just give us an idea of how safe an abortion is as opposed to a full term delivery. And I am talking about an early abortion.
A Okay. One of the most recent publications that speaks to this issue is a publication by Dr. Christopher Tietze in January of 1984 and Dr. Tietze quoted a case fatality rate for abortion as .5 per 100,000 procedures. That's about five per 1,000,000. That's for all abortions. Whereas, the case fatality rate for term delivery in that paper was approximately 11 per 100,000 live births, which means that the risk of term birth is approximately 25 times greater in terms of risk of death than abortion.

Now, in early abortion the estimates are—and we are talking about abortion performed six to eight weeks from the last menstrual period—the case fatality rate is less than one per 1,000,000 procedures. It is a very safe procedure. In fact, it is probably the safest surgical procedure being performed in the United States in this category of procedures.
Q What do you mean "in this category of procedures"?
A Procedures that involve invasion of a body cavity or a major organ of some kind.
Q Dr. Hern, do you have any rates of comparison comparing [242] the abortion to other types of out-patient surgery, say, for example, a tonsilectomy or some other procedure?

A Well, I think that the—some estimate that I have seen indicate that tonsilectomies are at least twice as dangerous as abortion, overall.

I consulted with a colleague who informed me that the death rate due to laparoscopic surgery, with or without sterilization, is approximately two per one hundred thousand procedures.

Q What do you mean by laparoscopic surgery, Doctor?

A Laparoscopic surgery involves the introduction of a laparoscope into the abdominal cavity. A laparoscope is a tube, a metal tube that is hollow and it is something that permits the physician to look through it into the cavity and it is introduced through the umbilicus, with or without operating instruments.

Q Dr. Hern, you have discussed these complications and the safety and the relative risks of abortion for us and, in your opinion, what factors would you single out as affecting the safety of the abortion procedure and the rate of complications, if you can, please?

A I would say that the single most important factor in safety of the abortion procedure is the skill and experience of the operating physician.

Q Why do you say that, Dr. Hern?

[243] A I feel that almost regardless of the length of gestation or the technique being used that if the operating physician is skillful and is experienced that he or she can perform this procedure with great safety, given the appropriate instruments.

Q How would a physician develop the necessary skill to perform the abortions that have the low complication rates that you have been discussing this morning?

A Well, the first step, of course, is to observe another physician who is skilled and experienced perform the procedure and to learn from that physician, as with any other surgical procedure.

The second step would be to actually perform that procedure under the supervision of a skilled and experienced physician.

And the third step is practice, and it takes a great deal of experience to learn how to do this; to do this properly.

Q Dr. Hern, are there any other factors that affect the safety of performing an early—or that affect the safety of the abortion procedure?

A Yes.

Q Would you tell us about those, please.

A Yes. The second most important factor, I believe, is the length of gestation. And it is very difficult to separate [244] the skill of the physician from the length of gestation in terms of a statistical analysis because the first is so subjective but, on a strictly objective basis, you would have to say that the length of gestation is probably the most important factor but I believe that, and clinical experience would tell me, that the skill is the most important.

In any case, the length of—

Q Can you break down—I am sorry.

A Excuse me.—

Q Can you break down what you mean by "gestation length," and can we do it in the periods that the Supreme Court has sort of designated, the relative periods?

A Surely.

Q And if you would start with the first trimester as opposed to the second trimester.

A Okay. On the first trimester the abortion procedure is exceedingly safe and in the second trimester the rate of complications and the case fatality rate goes up according to the length of gestation.

Q What about for the early part of the second trimester, let's say, you know, 12 through 15 or 16 weeks?

A Well, at this stage the complication and mortality rates are very comparable to first trimester rates. This is not

as complicated a procedure as the late second trimester abortions.

[245] Q Doctor, in addition to the skill of the physician or the gestational length of the pregnancy, are there any other factors, in your opinion, that affect the safety of the abortion procedure?

A The choice of abortion technique is a third major factor, I think, in the determination of the safety of the procedure.

Q And why would you say that?

A Well, for example, in first trimester there are various techniques available, of which the vacuum aspiration technique is the most—is the safest.

Q Do you have any idea how many first trimester abortions are done using the vacuum aspiration technique?

A I believe that 90 to 95 percent, at least, of all first trimester procedures in this country are done, are performed by vacuum aspiration technique of some kind.

Q Dr. Hern, what about during the second trimester, what techniques are used then to assure safety of procedure?

A The principal technique used for second trimester abortion in this country today is dilatation and evacuation methods.

The other methods that are used are the saline, urea and Prostoglanin installation techniques. There are some combinations of these methods in some institutions.

Q How does the safety of a second trimester D&E abortion compare to the safety of one of the installation methods, say [246] the Prostoglanin or the saline?

A Well, a very serious problem with the installation techniques is that they generally cannot be performed before the 16th week of pregnancy and this limits their usefulness a great deal and, in fact, the conventional approach was to require a woman who was between her 12th and

16th week, for example, to wait until the 16th week to have an abortion by an installation method.

We know now that the D&E method can be performed very safely during this time and the complication rates are very low, but, on the other hand, if you take the period between 13 and 16 weeks or between 16 and 20 weeks, even, the complication rates for installation techniques by themselves are several times higher and the case fatality rates are higher for the installation techniques than it is for the D&E method.

Q Doctor, just briefly, what do you mean by the "installation techniques"? I am sorry. Could you just tell us what happens in an installation abortion as opposed to a D&E.

A Okay. An installation technique, like saline, for example, would involve the placement of a needle into the amniotic cavity, withdrawal of some of the amniotic fluid and installation a hypertonic saline solution within the amniotic cavity, and essentially, that's the same thing that [247] you would do with urea.

With Prostoglanin it is not necessary to withdraw amniotic fluid; in that case the material is injected into the uterine cavity.

Q And then is the abortion completed by a process similar to, for example, labor?

Q Yes. The woman eventually would go into labor and deliver the fetus.

Q Dr. Hern, given the comparison rates between the installation and the D&E type of abortion procedures during second trimester pregnancies, do you have any idea as to which technique, the installation or the D&E, is more commonly used today?

A By 1980 I believe that approximately 85 percent of all second trimester abortions through the 15th week were done by D&E. I believe that the majority of abortions

at that time in the second, the late second trimester, were still done by installation techniques. But at the present time I feel that D&E is the procedure of choice and that is the principal method being used. We don't have the current statistics to demonstrate that, I don't believe.

Q Dr. Hern, when you are talking about a second trimester D&E, would you still use the same type of procedure, like, for example, local anesthetic?

A Yes.

[248] Q Okay. And are there any advantages to using a local anesthetic at this stage of the abortion process from the standpoint of avoiding complications?

A I think that local anesthesia is far the preferable method. The general anesthesia introduces all of these other risks at that stage and the risk or risks are more serious, in my opinion.

Q Is there any advantage to having the patient conscious during the abortion procedure?

A There is a great advantage.

I think that the, for example, the risk of perforation is there whether the patient is awake or not, with the D&E method, for example, but if the patient is asleep, why, first of all, the risk of perforation is greater, as I said, and if the patient is asleep and you perforate the uterus it is quite possible to grasp some other component of the peritoneal cavity, the bowel or some other organ, and to pull on it and that would cause a calamity.

Q How would that be avoided if she was not asleep and only under a local anesthetic?

A Well, the first thing is that if the patient is under a local anesthesia, or anesthetic, her uterus has more tone and is easier to distinguish as to where the wall of the uterus is when you are operating.

Q Would she know when a perforation had occurred, for [249] example?

A If you perforate the uterus the patient would know that immediately and she would tell you that she was having some unusual pain.

Also, experience shows that if you grasp an internal organ, at that point the patient does experience a very significant pain and she can tell you that. If she is asleep, she can't tell you that.

Q And how often does the complication of, you know, perhaps touching one of the other organs occur in your practice or nationwide, Dr. Hern?

A Well, nationwide in the D&E method I think that we would have to say that the perforation rate is higher than in first trimester; it is very difficult to say but I would say that it is closer to one in 250 or one in 500, whereas, it is a much lower rate with first trimester abortions.

In my practice, perforation has occurred once.

Q Dr. Hern, how would you characterize the abortion procedure in terms of being a major or a minor procedure?

A Well, I think—

Q First and early second we are talking about here, Doctor.

A I think that it is a minor procedure.

Q Why do you say that?

A Well, I think that a "major procedure," by definition, involves invasion of the peritonial cavity.

[250] Q What do you mean by the "peritonial cavity"?

A The peritonial cavity is the compartment of the body within which is contained the intestines, the liver, the spline and those structures and the uterus is, in a sense, within the peritonial cavity but the operator, unless there is a perforation of the uterus, does not enter the peritonial cavity itself. That would be an inadvertent problem in the abortion.

Q So, would you characterize it, then, as a minor medical procedure during the first and early second trimester pregnancy?
A Yes.
Q Dr. Hern, are you familiar with a gynecological procedure called the dilatation and curettage or the D&C?
A Yes.
Q How does that compare to first or early second trimester abortion?
A Well, D&C is sort of a generic name for a procedure, dilatation and curettage, and 20 or 25 years ago a D&C was generally done in the hospital under general anesthesia, and for, principally, diagnostic purposes. It was not often done for the purpose of abortion.

An abortion resulting from a D&C has, essentially, the same result as an abortion resulting from vacuum aspiration curettage but the D&C is distinguished by the fact [251] that vacuum aspiration is not used.
Q Are all D&C's used to secure an abortion?
A No.
Q All right. You mentioned "for diagnostic purposes," and what kind of diagnostic purpose, for example?
A Well, for example, if a woman has unexplained uterine bleeding in between her menstrual periods the physician may decide to do an D&C or a vacuum aspiration for an endometrial biopsy, for example.
Q A what?
A An endometrial biopsy or—endometrial aspiration.
Q And by "endometrial" you are referring to the lining of the uterus?
A Yes. These are all the same kinds of procedures and if a woman, for example, has bleeding after her menapause this may be an indication of cancer and so the physician may do a diagnostic D&C or vacuum aspiration

in order to determine whether in fact she is bleeding because she has cancer. So, those are some of the reasons why physicians would do this.
Q You mentioned in the first part of your discussion that as to the D&C procedure, that 20 or 25 years ago they were done in a hospital under general anesthesia. Is that still a common practice?
A No. I think that it does happen but I believe that many [252] physicians now do this procedure in their office as a matter of routine patient care.
Q With local or general anesthetic?
A Local.
Q Dr. Hern, based on your experience, both clinical and academic, could you describe for us what the physical dimensions of your office or any place in which a safe first or early second trimester abortion could be performed; just describe this as to your facility.
A Well, I have a waiting room—
Q Well, excuse me. Let me rephrase that.

What do you need in terms of the physical plant in order to perform a safe first or early second trimester abortion?
A Well, you need a waiting room and a place to see patients and you need one or more exam rooms, and the exam rooms can also be used for procedures.
Q What size are we talking about when we are talking about "an exam room"?
A Well, an average physician's exam room, I believe, is seven by ten feet, maybe a little bit bigger.
Q Are there any regulations in Colorado governing the size of an exam room?
A No.
Q What about a procedure room?
[253] A Well, essentially, you can use the same room for a procedure room.

Q A seven by ten?
A Seven by ten, and you might want it to be a little bit bigger if you are doing a late second trimester abortion.
Q Why would that be?
A Well, because you might want to have an intravenous fluid running and you might want to bring an ultrasound machine in, you might have more instruments, you might have more personnel to help you, that sort of thing.
Q You are talking about a late second trimester abortion?
A Yes, late second trimester abortion.
Q And what do you mean by a "late second trimester abortion" that would require the ultrasound and the i.v.?
A 20 to 24 weeks.
Q All right. Dr. Hern, what kind of equipment do you need to perform a safe first or early second trimester abortion?
A Well, to begin with, you need a clean, well lighted room and a normal standard ob-gyn gynecologic examining table; you need a table to put your instruments on, a rolling stool for the operator, a good light, an operating room light of some kind. It can even be a simple gooseneck light, which is adequate. There are others that are better but that may be adequate.
[254] You need antiseptic solution, you need certain instruments such as forceps, tenaculum, curettes and that sort of thing.
Q A vacuum aspirator?
A A vacuum aspirator, yes. That kind of a machine.
Q Where do you put the patient?
A The patient lies on the table and she—
Q What kind of table, Dr. Hern? We are not talking about something like this (indicating) are we?
A I beg your pardon?

Q We are not talking about something like this?
A No. I said a standard ob-gyn examinating table.
Q Okay. What do you mean by a "standard ob-gyn examining table"?
A Well, the standard ob-gyn examining table has, for example—well, it may have heel stirrups so that the woman can put her heels in there so she goes into the lithotomy position lying on her back with her knees apart or you may have knee stirrups so that the woman can rest her knees on these stirrups, that's one option.
Q Dr. Hern, are these standard obstetrical and gynecological tables found anywhere other than in an abortion facility?
A Oh, they are routine. They are found in both physician's offices, I would say. Certainly physicians who have any [255] occasion to do pelvic examinations, and that can include internists, pediatricians, family doctors, anybody like that.
Q Okay. Dr. Hern, I would like to show you what has previously been marked as Plaintiffs' Exhibits No. 4 and No. 9 for purposes of identification.

* * * * *

BY MS. CONNELL:
Q Let me show you what has been marked as Plaintiffs' Exhibit No. 4 for identification.
A Yes.
Q What is that?
A That's a standard gynecologic exam table, it appears to me.
Q Okay. And this is the kind that is found commonly, as you have referred to?
A Yes.
Q Okay. How about this, Dr. Hern, which has been marked as Plaintiffs' Exhibit No. 9 for identification?
A It looks the same.

Q Okay. And that is what kind of a facility or what kind of a surrounding? How would you characterize this room or how would you describe it?

[256] A Well, I would say it looks like a normal exam procedure room where any kind of routine kind of gynecologic procedure or exam could be performed.

Q Dr. Hern, the facilities that you have been describing as necessary for performing a first and early second trimester abortion, are those commonly found in a physician's office?

A Yes.

Q Can abortions in the first or early second trimester of pregnancy be performed safely in a physician's office that has the equipment that you have just described?

A Yes.

Q Dr. Hern, let's say that we have a practice in which the physician performs approximately 3,500 abortions per year during the first and early second trimesters of pregnancy, would you need any equipment or any physical plant facilities to perform that number of abortions in addition to the facilities that you have just delineated for us this morning?

A No. I think that you might need an extra room for a recovery room where the patients can recover after their procedures. Certainly you can allow the patient to recover in the procedure room where the procedure has occurred but if you have a large number of patients this might not be practical. But that room does not require any special equipment.

Q Dr. Hern, in your professional opinion, is there any [257] difference in the safety or the factors of risk as to an abortion performed in a physician's office such as you have described as opposed to an abortion performed in a facility that might perform, say, 3500 abortions per year?

A No.

Q What, in your opinion, makes up or what determines the risk or the safety of the procedure, Dr. Hern, the facilities?

A Well, as I said, the most important factors are the physician's skill, the length of gestation and the technique being used.

I think that the setting is almost irrelevant. I mean, if the setting is clean and is well lighted and has all of the normal accouterments of civilization it would be perfectly adequate. The average lawyer's office would serve quite well, with a few modifications.

Q Dr. Hern, if I might, just again, Plaintiffs' Exhibits No. 4 and No. 9, referring to those, Dr. Hern, would you look at these two pictures again for me, please.

A (Examining.)

Yes. All right.

Q Could you tell me whether those pictures represent a facility that, in your opinion, would be an appropriate place to perform first or early second trimester abortions?

A Yes, it would.

Q Dr. Hern, I would like to move on here and discuss just [258] briefly the Illinois Ambulatory Surgical Treatment Center Act and the regulations that were promulgated under that act.

Are you familiar with this act and its regulations?

A Yes, I am.

Q Have you reviewed this act and its regulations?

A Yes, I have.

* * * * *

MS. CONNELL: Your Honor, at this time I would like to tender to the witness what previously has been marked as Plaintiffs' Exhibit, for purposes of identification, No. 10 and it is a copy of the regulations promulgated under the Illinois Ambulatory Surgical Treatment Center Act.

THE COURT: Yes.
BY MS. CONNELL:
Q If I may hand you these, Dr. Hern.
A All right.
Q Dr. Hern, based upon your review of these regulations and the act pursuant to which they were promulgated, do you have an expert opinion about whether a facility that was designed to conform completely with the ASTC regulations and, when you consider those regulations as a whole, provides a facility that is medically necessary for the performance of [259] a safe first or early second trimester abortion?
A Yes, I do have an opinion.
Q What is that opinion?
A In my opinion, these regulations are not medically necessary.
Q What is the basis for that opinion, Dr. Hern?
A Well, I find very little in the regulations that have any relevance to the provision of abortion services and I see nothing there that would really advance the safety of abortion care, and, in fact, I think that the regulations, by themselves, would tend to impede the provision of abortion service in many respects.
Q Why do you say that they would tend to impede the provision of abortion services, Dr. Hern?
A Well, essentially, the regulations state that you have to build a hospital in order to perform abortions and there is just no justification for that. It would cause tremendous expense and it would impair access to safe abortion services for women who need them and I think that that would contribute to a serious public health problem.
Q Why do you say that it would contribute to a serious health problem, Dr. Hern?
A Well, first of all, I think that the regulations would discourage the provision of abortion services and that it

would make it difficult for women to find abortion services [260] and it could cause delays, for example, in obtaining an abortion and that would contribute to the risk of the abortion itself, as we know from the other statistics.

Some women might not be able to obtain abortions and certainly the provision that the abortion services have to be provided in a separate facility would expose the women to embarrassment and difficulty in obtaining the service and would impair her confidential relationship with her physician.
Q Dr. Hern, do you have a professional opinion on whether it is medically necessary to have abortion facilities or facilities that are devoted primarily to the performance of abortions to have a special license from the state?
A I do have an opinion.
Q What is that opinion, Dr. Hern?
A I do not feel that it is medically necessary for the state to license abortion facilities, per se.
Q What is the basis of that opinion, Dr. Hern?
A Well, first of all, I don't see any need for that. We already have established that abortion is among the safest, if not the safest, surgical procedure being performed and almost all of these abortions over the last 15 years in this country have been performed in facilities that are not licensed. So, I think that that clearly shows that this can be done quite safely and that there are numerous mechanisms for encouraging practitioners to provide safe abortion [261] services.
Q And when you say "practitioners" you are referring to licensed physicians, Doctor?
A Licensed physicians.

The other thing is that the state licenses physicians, as it does license lawyers and other professional people, and that that is the point of public control or accountability

and if the physician is not practicing good medicine the physician can lose his or her license, and, in fact that occurs.

There are numerous mechanisms within the medical profession, medical society grievance committees, and also within specialty groups, that encourage and sanction the practice of good medicine and good medical care, and certainly in this field.

Q Dr. Hern, in your opinion, would separate licensure of an abortion facility reduce the medical risks for a woman who went to that facility for a first or early second trimester abortion?

A No.

Q Dr. Hern, if I may have you turn your attention just briefly to the regulations that are contained in Plaintiffs' Exhibit for purposes of identification No. 10, I would like you to direct your attention to Regulation 205.1320.

A 1320?

[262] Q Yes.

A Okay. If I may have a moment here.

Okay. I was looking at the wrong part. All right.

Q Dr. Hern, what does Subpart (a) of this regulation, Regulation No. 1320, require?

A It says: "This facility shall be identifiably separate from other facilities and functions."

Q Dr. Hern, in your opinion, is that medically necessary for an abortion facility to be "identifiably separate from all other facilities and functions"?

A No.

Q Now, what is the basis of that opinion?

A Well, there is just no reason for it. The abortion service can be provided in any normal physician's office and the requirement that it should be separate is redundant; it is unnecessary and there is no reason why it should be separate.

If the physician chooses to have a specialty abortion practice and the facility is separate and identifiable, that's fine but I don't think that there should be any restriction which says that it must not—that there shouldn't be any restriction saying that it must not be separate either. That's a matter of individual practice. But there is no medical reason why the facility should be separate and identifiable.

[263] Q Would it enhance the safety of the procedure in any way that you can think of?

A Not in any way.

Q Would it have any impact, Dr. Hern, perhaps, on the physician or on his or her patients to require the facility to be identifiably separate?

A Well, depending upon the community atmosphere toward abortion, for example, a requirement that the facility be separate could impede the provision of the services and could impede a woman's access to services.

For example, it could subject her to harassment and ridicule and embarrassment if she is going to seek an abortion, and it certainly could subject the physician to considerable harassment by those who oppose abortion.

Q Dr. Hern, I'd like you to turn your attention now, if you would, to Regulation 205.1360 or 15, 16.

A Okay.

Q Dr. Hern, would you look at Subpart (a)(1).

A Yes.

Q Which deals with examination rooms.

A Yes. All right.

Q Dr. Hern, in your opinion, is there any medical justification for requiring an exam room to have a minimum, and I quote, a "minimum clear area of eight square feet"?

A No.

[264] Q Would having a room, an examination room, of that particular dimension, would that do anything to

enhance the safety or reduce the risk of the first or early second trimester abortion procedure?
A No.
Q What do you need for an exam room, Dr. Hern?
A Well, you have to have an exam room that is big enough to put the table into or that will receive the table and big enough to be able to open the door and walk around the table, and that really doesn't require a great deal of space.

You may or may not have sinks in the exam room. So, I mean, there are a variety of circumstances that one can find.

If you were going to build a new facility you might—you might, as your option, make the examining room bigger but, on the other hand, it certainly is not necessary and, in fact, most physicians' offices do not have exam rooms that big.
Q Dr. Hern, I would like you to turn your attention now to Subpart (b)(1), the 250 square feet procedure room.

Dr. Hern, in your expert opinion, is there any medical justification or any medical necessity for having a procedure room for first or early second trimester abortions having dimensions of 250 square feet?
A No, I can't think of any.
Q How big are your procedure rooms, Dr. Hern?
A Well, I think that the smallest procedure rooms are [265] about seven by nine feet or seven by 10, something like that. I haven't measured them for a while.

I have one procedure room that is a little bit bigger.
Q And what procedures do you perform in that procedure room?
A The large—
Q What procedures do you perform in that large procedure room, or that larger procedure room?

A The large procedure room is used, principally, for late second trimester abortion procedures.
Q The ones that you discussed earlier where you need, possibly, the additional equipment, such as the ultrasound and the, perhaps, intravenous equipment?
A Yes. Right.
Q Dr. Hern, do you have any idea what the dimensions are of that larger procedure room in your facility?
A I think that it is about 12 by 15 feet. I am not exactly sure.
Q Is that appropriate for your medical needs, Doctor?
A Oh, it is—we rattle around in there; it is bigger than we need.
Q Dr. Hern, if you would direct your attention to—well, first, let me ask you just one further question: Can you think of any way in which the safety of the first or early [266] second trimester abortion would be enhanced by having a procedure room that was 250 square feet in dimensions?
A No.
Q Dr. Hern, then, if you would direct your attention, please, to Subpart (b)(2) of Regulation 205.1360.
A Yes.
Q Is there any medical need or any medical necessity for, quote, "A communications system connecting with the control station," in the procedure room?
A No. I think that that—well, first of all, that assumes that you have a "control station," which is not necessarily true.
Q Do you need a control station in an out-patient abortion facility?
A No.
Q Are you aware of any health facilities that do have a control station?
A Yes.

Q What would those be?
A St. Joseph's Hospital in Denver, I believe, has a control station on each floor but I don't believe that they do abortions there.
Q Dr. Hern, are you on the staff of St. Joseph's Hospital?
A No.
Q Are you on the staff of any hospital?
[267] A I am on the staff of Boulder Community Hospital.
Q Do they have a control center or control station at Denver Community Hospital—or, excuse me, the Boulder Community Hospital?
A I believe that each floor has a reception and nurses' desk. I am not sure if they call it a "control station" or not but the operating room has a head nurse's desk. I suppose that that is a "control station."
Q Is there any medical necessity for having a control station in an abortion facility?
A Not that I know of.
Q Would the provision or the existence of a control station do anything to increase the safety of the first trimester or early second trimester abortion procedure, Dr. Hern?
A No.
Q Dr. Hern, if you would take a look at Section (c)(2) of Regulation 205.1360 dealing with "recovery room."
A Yes.
Q You testified earlier that you thought that you needed a place or a space for patients to recover or rest after the performance of an abortion; is there any reason or any medical necessity for having a recovery room with a minimum clear area of 100 square feet, Doctor?
A No.

Q Can you think of any way in which a facility having a [268] recovery room with a minimum dimension of 100 square feet would improve the safety or lower the complication rates of a first or early second trimester abortion?
A No.
Q Dr. Hern, if you would also look at Subpart 3 of Subpart (c) of Regulation 1360.
A Yes.
Q Do you need a drug distribution station in your recovery room?
A No.
Q Would you put one in your recovery room, Dr. Hern?
A I would not.
Q Why is that?
A Well, for one thing, I don't want the patient to have access to drugs without supervision and I think that it is simply not necessary. I don't keep my drugs in the recovery room and I think that they should be under the nurse's control or the physician's control at a separate location.
Q Dr. Hern, what about a nurse's station? Do you need a nurse's station in a recovery room?
A Not in a recovery room, no.
Q How about a hand-washing facility in the recovery room?
A In Colorado we call that a "sink," and I don't believe that it is necessary in a recovery room.
Q How about the storage space? Do you need that in the [269] recovery room?
A No.
Q Would any of these provisions that we have discussed in Subpart (c) enhance the safety of the abortion procedure?
A No.

Q Dr. Hern, let's take a quick look at Regulation 205.1400, if you would, please.
A Yes.
Q Dr. Hern, is there any—
THE COURT: What is the number again?
MS. CONNELL: 205.1400, your Honor.
THE COURT: Okay. Thank you.
BY MS. CONNELL:
Q Dr. Hern, is there any—first I want you to look at Subpart (a) here.

Is there any reason or any medical justification for having an eight foot corridor or a five foot corridor in an out-patient abortion office or facility?
A No.
Q Would having a corridor of that dimension enhance the safety, Dr. Hern?
A No.
Q Do you have such an eight foot corridor in your facility, Dr. Hern?
A No.
[270] Q Can you think of any reason to have one?
A I have never seen a patient that fat and I have never had to drive a car in my office and so I think that there is no reason why that would be necessary.
Q Dr. Hern, if you would take a look at Subpart (f) of this Regulation 205.1400, and that's Subpart (f), which requires a minimum width of doors requiring access for stretchers, that that be 3.8 inches in diameter, or in width, is there any medical necessity for that?
A No.
Q Are the doors in your facility that large?
A No.
Q Do you transport patients on stretchers, Dr. Hern?
A Yes.

Q You do, in your facility?
A Yes.
Q And do you—
A Or I should say, on a very rare occasion we have had an ambulance come to help us with patients whom I wished to transfer to the hospital and they have entered these rooms quite comfortably with a stretcher or we have taken the patient out on the airplane loading cart that we have.
Q Dr. Hern, would you take a look, then, at Subpart (g) which requires swing doors "on doors of all openings between corridors or room subject to occupancy," and let me ask you, [271] is there any medical necessity for swing doors? Does that enhance the safety of the procedure at all?
A No.
Q Dr. Hern, do any of the regulations that are contained primarily in Subpart (i) and (j) and (k) and (l), in your opinion, which deal with physical plant requirements, do anything to enhance the safety of the abortion procedure?
A What parts, (j), (k) and (l), are you talking about?
Q Yes. Take a look at (i), which is the provision that we have been dealing with, Subparts (j), (k) and (l).

Are the regulations that are detailed in those medically necessary for the construction of a safe facility in which to perform first and early second trimester abortions, in your opinion?
A No.
Q Could you have opened up your clinic, your office, had you been required to comply with these procedures, Dr. Hern?
A Well, aside from the particular points in these four subsections that you are referring to, I would say that, as a general rule, it would have been impossible for me

to open my office ten years ago if I had had to comply with these regulations.

Q Dr. Hern, just a couple more quick questions about one more of the regulations.

If you would turn to the part of the regulations [272] dealing with air conditioning and air standards, and that's 205.1540.

A 1540?

Q 1540, yes.

A Yes. Let's see here.

All right.

Q Now, that includes, also includes Table A, which I believe is in the back of the little regulatory book, and, Dr. Hern, in your opinion, what kind of heating and ventilation do you require in an out-patient facility in which you perform first and early second trimester abortions?

A I think a normal heating and ventilation system.

I, frankly, have never examined my heating and ventilation system in detail, I let the city building inspectors do that.

Q Dr. Hern, do you need to control, for example, the filter beds, the pressure relationships and the air changes per hour in the rooms in which you perform first and early second trimester abortions?

A No.

Q Are those kinds of air changes and regulation of ventilation, are they medically necessary for the performance of a first or early second trimester abortion?

A No.

Q Would they enhance—would compliance with those [273] regulations enhance the safety of the first or early second trimester abortions?

A No.

Q Why is that? What is the basis of that opinion, Dr. Hern?

A I, quite frankly, don't see what these things have to do or that they have anything to do with the practice of medicine.

I suppose that if you were performing open heart surgery or if you were doing a hip replacement operation then these considerations might be significant.

Q Why aren't they significant, then, in the performance of a first or early second trimester abortion?

A Well, in the first place, I think that this is very low risk operation to begin with and the air contamination, for example, is not significant in terms of the safety of the procedure.

Q Why is it, Dr. Hern?

A The procedure is conducted almost entirely within the patient's body and there is a certain amount of the uterine cavity that normally occurs, or commonly occurs, I should say, and simply by the introduction of instruments through the cervical canal, the air in the room doesn't affect that whatsoever, and there is no demonstrated need for this kind of air conditioning equipment and regulations that I know of that would enhance the safety of the abortion procedure.

[274] I have never heard of most of these things and I find it all quite baffling and somehow or other we have struggled along for about 12 years in Colorado performing abortions very safely without any knowledge of this whatsoever.

Q Dr. Hern, let's leave the physical plant requirements behind us for a moment and, if you would turn to Subpart (g) of the regulations, which are entitled "Additional Requirements for Facilities in which Obstetrical and Gynecological Procedures are Performed"—

A Yes.

Q Dr. Hern, in your opinion as an expert in the area of abortion services, is there any justification for singling

out the abortion procedure or the provision of abortion services for special regulation?
A There is a—
Q That is, apart from other out-patient or other surgical procedures?
A There is no medical justification that I know of.
Q What is the basis for that opinion, Doctor?
A Well, the basis for that opinion, I believe, is the outstanding record of safety that has been established in the provision of abortion services in this country and I think that that has principally resulted from the lack of regulations and that, in fact, in those areas where abortion services are over regulated there has been a failure to advance with [275] current abortion technology and to permit physicians to provide the safest kind of abortion procedures.
Q Can you give us an example of that, Doctor.
A New York State, I think, is the most outstanding example of that that I know of.
Q And what do you mean by that?
A Well, for example, in New York State it is required that there be certain things, that abortions be performed in licensed facilities and that, I should say, that second trimester procedures, for example, cannot be performed outside of a hospital, if I am not mistaken, and, as a result, the D&E method for second trimester abortion has not been adopted in New York State nearly to the extent that it has been in other parts of the country and, in fact, I have invitations to come there to speak to inform them about this method, and this is a method that we have been using in other parts of the country for years.
Q What are the consequences to women patients in New York as a result of not having the developed D&E method of abortion available to them?

A Well, for one thing, they have experienced much higher complication rates in second trimester abortions than patients in other parts of the country where the D&E method is available and also the expense that the women have experienced is more significant.
[276] Q Is that a factor of the use of the installation techniques that you referred to?
A Yes.
Q Dr. Hern, would you take a look at Subsection 205.720.
A Yes.
Q Is there any reason, any medical reason, or justification that a facility in which first and early second trimester abortions need to employ a nurse with, quote, "postgraduate education or experience in obstetrical or gynecological nursing"?
A No.
Q What is the basis for that opinion, Doctor?
A Well, in the first place, much of the postgraduate education that I have seen for nurses has little relevance to abortion practice, per se, even though it may be an important educational experience, but it has low bearing on abortion services.
Q Why is that, Dr. Hern?
A I really don't know. I haven't—I don't believe that medical education in general, including nursing education, has paid very much attention to abortion services in this country.

The other thing is that experience in obstetrical and gynecological nursing, that would certainly be helpful, but, on the other hand, nurses with emergency room experience [277] are really far better prepared, I think, in some ways, to help in an abortion facility.

So, I think that it really depends upon the person and their attitude much more than the specific training. And

I would be reluctant to impose any particular kind of training on a nurse before accepting her as an assistant.
Q All right. Thank you, Doctor.
Would you take a look, if you would, please, at Regulation 205.730.
A Yes.
Q And I would like to direct your attention to Subpart (b)(3) of that, Dr. Hern.
A All right. Yes.
Q Now, you testified earlier that you do provide counseling in your facility, is that right, Doctor?
A Yes.
Q And do you consider that a part of—well, why do you provide it, Dr. Hern?
A Well, I believe that it is important for each patient to have not only a good understanding of the procedure that she is going to be having and how she got pregnant and what the methods are for her, I mean, for her to be permitted or to permit her to avoid unwanted pregnancies in the future.
Q Well, do you say the same things to every patient, Dr. Hern? Do you give the same counseling?
[278] A In general, yes. Although it really depends upon the individual patient as to how much we give as to that but I also think that—how much emphasis we give and as to what, but, as I say, it is also important for the patient to have an opportunity to express her feelings about the pregnancy and about the abortion and, perhaps, the relationship in which it occurred.
Q Would you always, Dr. Hern, for example, include in your discussion with the woman a discussion of the alternatives for dealing with pregnancy?
A Yes. And depending also to some extent on the patient's interest in this subject. Some patients absolutely refuse to discuss alternatives; they come in and they have

their minds absolutely made up about what they want to do and they are impatient to get on with the process and they really do not wish to spend a great deal of time talking about, for example, adoption.
Q Dr. Hern, if you would turn real quickly to 205.740, would you read that regulation to yourself, please.
A (Examining.)
Yes.
Q Is there any medical reason for restricting the performance of abortions in an out-patient facility to those patients, quote—or, excuse me, is there any reason to restrict the provision of out-patient abortion services to [279] 12 weeks of gestational length of pregnancy?
A No.
Q What is the basis for that opinion, Dr. Hern?
A Well, from my own experience, we have been providing second trimester abortion procedures in my office on an out-patient basis for ten years and we have the lowest complication rate in the medical literature.
Q Dr. Hern, are you telling us or is your medical opinion that all of the provisions or regulations contained in Subpart (g) are medically unnecessary?
A Yes.
Q Why do you say that, Dr. Hern? Are all of them inconsistent with good medical practice?
A No. In fact, there are some aspects that are consistent with good medical practice, good standards of medical practice, but, on the other hand, the mere presence of the regulations can provide an impediment to the provision of services and, taken as a whole, the regulations would positively obstruct the provision of abortion services.
MS. CONNELL: May I have just a moment, your Honor?
THE COURT: Yes.
(Brief interruption.)

BY MS. CONNELL:
Q Dr. Hern, do you have an opinion as to the relative safety of the abortion—
[280] MS. CONNELL: Let me withdraw that, your Honor, please.
BY MS. CONNELL:
Q Dr. Hern, you testified earlier that the skill of the physician was, in your opinion, the single most important factor for the provision of safe first or early second trimester abortions?
A Yes.
Q Do you have any opinions, Dr. Hern, as to whether a physician who has a, shall we say, garden variety office practice and does maybe five or ten abortions per month would be as skilled, for example, as a physician who performs, say 3,500 abortions a year?
A I think that almost by definition the physician who performs only a few abortions per year would be far less skilled than the physician who performs several thousand procedures per year.
Q Why do you say that, Dr. Hern?
A Because I think that an abortion, almost more than any other procedure that I know, requires lots of experience and practice and it is not a procedure that you learn to do well after even a few hundred or even a few thousand procedures.

And it is like others in the respect that, for example, if you have someone who does 100 appendectomies a year, that physician is going to be better at doing [281] appendectomies than the doctor who does one or two appendectomies a year, or any other kind of procedure.
Q Doctor, based upon that opinion, is there any reason to regulate a physician who performs 3500 abortions per year more stringently or more restrictively than a physician who performs 50 abortions a year?

A No. In fact, I think that the physician performing 3500 a year is less likely to have serious complications than the physician performing a few every year.
Q Dr. Hern, are you familiar with one of the plaintiffs in this action, Dr. Richard Ragsdale?
A Yes, I am.
Q How are you familiar with Dr. Ragsdale?
A Well, I have met Dr. Ragsdale at numerous professional meetings, medical meetings, at which we have exchanged information and opinions about the various aspects of medical practice in abortion.
Q Do you have an expert opinion on Dr. Ragsdale's skill as a provider of abortion services during the first and early second trimester of pregnancy?
A I think that Dr. Ragsdale is one of the experts in this country in the provision of abortion services.

* * * * *

Cross-Examination

* * * * *

[286] * * * Q Do you have any personal knowledge as to any methods or features used in the State of Illinois for disciplining a licensed physician?
A No, I don't.
Q Now, in general terms, you discussed the regulations, which I believe you have in front of you, and that is—that's Plaintiffs' Exhibit 10, is it?
A Yes.
Q And you have reviewed those regulations?
A Yes, I have.
Q Can you tell me whether all of the requirements imposed under those regulations are medically unnecessary to the performance of first and early second trimester abortions?
A I think that it is important to distinguish between the contents of the regulations and the merely presence of the regulations.

I think that the regulations themselves tend to produce a chilling effect on the provision of abortion services.

There are certain components of the regulations that are consistent with safe standards of medical care; on the other hand, they are superfluous because they are the things [287] that people do anyway. It is comparable to telling a lawyer, for example, that you must write a legible sentence in English if you are going to file a brief. That goes without saying. So, I think that to the extent that the regulations reflect some standard of medical care that is acceptable, they are unnecessary.

Q So, now, with regard to the content rather than the presence of those reg's, Doctor, can you tell me which regulations do not depart from accepted medical procedures for performing first or early second trimester abortions?

MS. CONNELL: Your Honor, I will object at this point. I think that that is an overly broad question that clearly exceeds the scope of the direct examination and it would require Dr. Hern to go through each of the 60-some pages of regulations and say "Consistent," or "Not consistent."

THE COURT: Well, all right. He is just asking him what he knows.

I will let him answer if he can; if he cannot, he cannot.

The objection will be overruled.

You may answer, if you can.

A I don't find any aspect of the regulations that are medically necessary and that enhance the safety of abortion procedures.

* * * * *

[292] * * * Q Desirable or acceptable to whom, Doctor?

A To either the patient or the physician, and it might be the physician's judgment that it is perfectly okay for

her to leave at 50 minutes or 55 minutes or 45 minutes or 30 minutes.

And I think that physicians have different patterns of practice with regard to this in their evaluation of the patient and I think that it is very difficult, if not impossible, for someone, ex cathedra, in a sense, to impose a regulation that is really rational.

Q So, it is irrational to keep a patient in the center for at least an hour following the procedure?

A I didn't say that.

Q Am I wrong or am I right when I say that it is irrational to keep the patient in the center for one hour following the procedure?

A You are wrong.

MS. CONNELL: Your Honor, I object. That clearly mischaracterizes the testimony of Dr. Hern.

MR. FLAHAVEN: This is cross.

THE COURT: Well, the record is clear. The objection [293] will be overruled.

I understand what is going on. You may proceed.

BY MR. FLAHAVEN:

Q Doctor, do you remember the question?

A Could you repeat it, please.

MR. FLAHAVEN: Will the court reporter please read that back.

(Question and answer read.)

BY THE WITNESS:

A I think the point I would make is that it is irrational to require that all patients stay one hour following the procedure regardless of the experience that they have had or their medical condition.

In fact, it may be prudent to have certain patients stay for one hour or longer, depending upon the patient's condition, and the kind of operation that she has had.

I think that this is a matter or decision that the individual physician has to make, has to decide, and taking into account the patient's need and her medical status.

* * * * *

[299] * * * Q Now, turn up to 205.1540.
A 205—pardon me?
Q 205.1540.
A Okay.
(Examining.)
Q Now, on direct testimony you indicated that there was a low risk factor, and maybe you can explain it a little better than I can, with respect to air contamination in abortion procedures?
A I think that the point that I am making is that it is not necessary to go to any special precautions to filter the air in a physician's office where abortions are being performed; that there is no particular additional risk involved by having normal room air in the building and that ventilation systems, for example, that are quite normal in a physician's office are adequate.

We have not, for example, gone to any special lengths to set up an air conditioning and ventilation system as I find described here.
Q Do you know what air conditioning, heating and ventilation system requirements are—
MR. FLAHAVEN: Strike that.
BY MR. FLAHAVEN:
[300] Q Are you familiar with any air conditioning, heating and ventilation system requirements in any city or county in the State of Illinois?
A No, I am not.
Q Now, getting back to this problem of risk through air contamination, is there an increase in its risk if during the abortion procedure there is a perforation of the uterus?

A I am sorry, what is your question?
Q During an abortion procedure, is there a risk of contamination through the air if the uterus is perforated?
A The uterus is inside the body and the air does not impinge upon the uterus and if you perforate the uterus that is a result of the doctor pushing too hard on the curette or the dilator and it has nothing to do with the air.
Q It has nothing to do with the air?
A No.

In the Middle Ages that was called the "Miasma Theory of Disease."
Q I believe you also testified as to the, in your opinion, the lack of any need for a licensure of a facility which is performing abortions or abortion procedures, isn't that your opinion?
A I do not believe that any particular licensing procedure is necessary.

* * * * *

[303] * * * BY MR. FLAHAVEN:
Q Now, you discuss on that page, in terms of patient evaluation, laboratory tests.

Could you explain to the Court what laboratory tests are routine for abortion procedures.
A Well, as I have described here, that, aside from a urine screening exam for pregnancy, which I mentioned earlier, that the routine laboratory work should include a hematocrit of hemoglobin, an Rh screening test and dip stick urinalysis. What that means is, there are little kits that are available with pieces of paper that are impregnated [304] with certain chemicals and you can dip that into the urine and then tell—well, that will tell you such things as the Ph of the urine, whether or not there is sugar or protein available—present, I should say—and that sort of thing.

Now, that is a very limited and elementary test which can be applied very simply.

Those are the principal tests which I recommend.

Q Now, I believe that you indicated on that page that there is a different or an additional test for black patients?

Would you explain that to the Court.

A Well, I think that the presence of sickle cell traits is higher in black women than in other groups in the country and that it is a good idea to arrange for a woman, a black woman, to have a sickle cell test or testing for sickle trait or for sickle cell disease, particularly if she is thinking about taking birth control pills or if she is going to have a late second trimester abortion, particularly by the saline method. We have found that patients who have those traits may be likely to have a sickle cell crisis. Now, these are exceedingly rare events and they are almost always seen in women who actually have sickle cell disease but I think that it is something—and it is something that can be done either in the clinic or the patient can have that done in some other facility.

* * * * *

[311] Q Doctor, is it your opinion that counseling is an indispensable part of a thorough preoperative evaluation and preparation of a patient for an abortion procedure?

A Yes, it is.

Q Doctor, is it your opinion that in medical practice there are few surgical procedures given so little attention and so underrated in its potential hazard as abortion?

A Yes.

* * * * *

[313] * * * BY MR. FLAHAVEN:

Q Doctor, is it your opinion that the tissue obtained during the abortion procedure must be examined immediately afterwards by a competent person, if not by the physi-

cian, and it must be reviewed in all cases by the operating physician or a physician properly delegated for this task?

A Yes.

BY MR. FLAHAVEN:

Q Doctor, is it your opinion that the purposes of recovery procedures are to allow the patient to relax and receive postoperative instructions and to determine the presence of immediate postoperative complications?

A Yes.

Q Further, Doctor, is it your opinion that the routine use of recovery area in an ambulatory abortion facility is mandatory?

A Yes.

[314] BY MR. FLAHAVEN:

Q Doctor, is it your opinion that first trimester patients should stay approximately one hour from the time they arrive in the recovery room?

A Yes.

Q Your book, on Page 221—

MR. FLAHAVEN: That's Page 221, counsel.

BY MR. FLAHAVEN:

Q Your book, on Page 221, contains a list of basic equipment necessary for a small abortion practice, and by a "small abortion practice" you mean five to 25 patients per week—

A Yes.

Q —on a first trimester out-patient laminaria local anesthesia model?

A Are you asking me a question?

Q Yes.

This list on Pages 221 and 222 of your book contain that equipment?

A Yes.

Q And that, on Page 223 of your book there is a list of equipment needed in addition to the equipment which is

contained or listed on Pages 221 and 222 and this equipment is to perform D&E procedures?
A Yes. But what is your question?
[315] Q The equipment on 223?
A What about it?
Q Is for D&E procedures?
A I said here that the equipment listed—"The following additional items of equipment are either necessary or recommended."
Q Okay. Now, is it not your opinion that early second trimester D&E programs can be conducted without all of the items listed on Page 223, "but, however, the risks of calamity in the operating room decline somewhat when the proper equipment is immediately available or in use when doing these procedures"?
A Yes. That's on Page 223.
Q And that's your opinion?
A Yes.
Q And it is also—
A I said that early second trimester D&E programs can be conducted without all of the items listed.
Q And then you have that proviso about—
A I think that the—
Q —about the risk of calamity or risks of calamity and—
A Yes. The choice of what is necessary from that list to supplement the first trimester equipment depends on the operator, it depends upon as to how far into the second trimester the operator will be going with the procedures and [316] various other factors.

I do not say that anyone who does second trimester procedures must have all of these items because they certainly don't relate, for example, necessarily, to early second trimester procedures, some of them.

BY MR. FLAHAVEN:
Q Doctor, is it your opinion that regardless of size, complexity or philosophical orientation of the abortion practice, a clear line of accountability in medical decision-making and responsibility must be established and maintained?
A Yes.
Q And, further, Doctor, is it your opinion that in a private medical practice of any kind the physician or physicians who operate the practice are responsible for all actions taken, whether they are aware of all actions taken with regard to their patients or not?
A Yes.
Q And, Doctor, isn't it your opinion—or is it your opinion that in a non-profit or lay operated clinic the medical director is responsible and liable?
A Yes.
Q Further, Doctor, is it your opinion that if the clinic has no medical director the responsibility and liability for medical decisions may rest on people who have no understanding [317] or professional experience with these responsibilities?
A Yes.
Q And, finally, is it your opinion that those who suffer most under the latter arrangement are likely to be the patients?
A Yes.
Q Continuing on that page, Doctor, and with respect to facilities where second trimester abortions are to be performed or in facilities in which 50 patients per week or more are to be attended to, under those circumstances isn't it your opinion that they require the addition of one physician or one part-time physician, a total of two or three nurses, a full-time receptionist, a laboratory/instrument technician, three to five counselors, depending upon

the scheduling and whether individual counseling is provided and one administrative person?
A Are you asking me a question?
Q Isn't that your opinion?
A Yes.

* * * * *

[321] * * * BY MR. FLAHAVEN:
Q Now, Doctor, is it your opinion with respect to arrangements with the nearest hospital for emergency hospitalization, it is best if the medical director or principal physician has staff privileges?
A Yes.
Q Further, Doctor, is it your opinion that if he does not, that there should be a hospital transfer agreement?
A Yes.
BY MR. FLAHAVEN:
Q Now, Doctor, with respect to a training program for counseling, is it your opinion that because of the amount of material to be imparted, training of counselors should include a minimum of 16 hours each of medical training in counseling techniques?
A Yes.

* * * * *

Redirect Examination

* * * * *

[328] * * * What do you mean by a "hospital transfer agreement," Dr. Hern?
A Well, this could either be a formal or an informal agreement. For example, you could have a written contract or agreement with the hospital or with a hospital which says that in the event of an emergency that Boulder Community Hospital, for example, or Cook County Hospital, will accept a patient from Boulder Abortion Clinic, or whatever, for purposes of emergency treatment.

Now, that, in itself, doesn't necessarily solve the problem of the patient's care. The physician providing abortion services, for example, has to, if that physician doesn't personally directly take care of the patient, it would be advisable to have an agreement with another physician on the staff of the hospital to provide the care and, for example, a verbal agreement between a physician or physicians can be a perfectly acceptable transfer agreement.
Q Why would a physician performing out-patient abortions choose to have, you know, the informal written—excuse me, the informal verbal type of agreement rather than a written transfer agreement, for example?
A Well, I just don't think that it is necessary to have a written agreement. Many of these things are taken care of in a [329] professional way as by a communication between colleagues.
The other thing is, too, I think that a written agreement sometimes would subject the institution or the individual physician who makes the agreement to harassment by opponents of abortion, and this certainly has been a problem in some communities.
But, for example, even if I had done a residency in obstetrics and gynecology and I had plenty of experience doing abdominal operations, I have had so few occasions during the last 12 years, or even 15 years, to perform abdominal surgery that, even with full training in that, I would ask a colleague to help me and to be the principal surgeon in such a case.
Q So, in the event of a complication that requires hospitalization you would need that—
A Yes. In other words, if it is a routine complication of some kind where I may simply say, "Well, I want to put this patient into the hospital to observe the patient overnight," and no surgery is contemplated, I don't have to

check with anybody; I can put the patient in the hospital and supervise the patient.

And, if I think that it is necessary, I can call a colleague and say, "I think that this person is in trouble and I think that we may have to operate and I would like to have your opinion."

[330] Q Is that standard medical practice?

A That is standard medical practice.

And, on the other hand, if I decide that I think that the patient needs a laparotomy, even though I might have privileges to do it, since I have so infrequent occasion to do that, I would be likely to call on a colleague who does abdominal surgery every week and who is used to doing it.

By the same token, that colleague may do an occasional abortion but think that he would be better to send the patient to me to do his patient's abortion because I do that all the time.

Q Dr. Hern, one last question on the regulations and then I hope that we can retire them, at least for purposes of your examination.

A Yes.

Q Dr. Hern, I would like you to direct your attention to Subpart (i) of the regulations, which is entitled "Building Design, Construction Standards and Physical Requirements."

A Yes.

Q And it starts with Regulation 205.1310.

A Yes.

Q And I would like you to continue directing your attention to Subpart (i) through Regulation 205.140—excuse me, 1410.

A Okay.

Q Doctor, are you familiar with—have you reviewed the [331] regulations contained in Subpart (i)?

A Yes.

* * * * *

BY MS. CONNELL:

Q Doctor, is compliance with all of the regulations contained within Subpart (i) of these regulations medically necessary for the construction or operation of a facility in which first and early second trimester abortions are performed in a medically appropriate fashion?

A No.

Q Dr. Hern, I would also like you to turn your attention to Subpart (j) which is inclusive of Regulations 205.1510 and ask you whether you have reviewed and are familiar with those regulations?

A Yes.

* * * * *

[332] BY MS. CONNELL:

Q Doctor, in your professional opinion, are the regulations included in all of Subpart (j) which is entitled "Mechanical," medically necessary for the operation of a facility in which first and early second trimester abortions are to be performed in a safe and medically appropriate fashion?

A No.

MS. CONNELL: Your Honor, I have nothing else.

THE COURT: All right.

I have one question that I would like to ask the doctor and then I will let the state have any further questions that they wish and then finally the plaintiff.

Do you know if either Illinois or any other state specifically regulates any other surgical procedure other than abortion, such as a D&C or any operation or procedure in obstetrics or gynecology, in that field?

THE WITNESS: I am not aware that they do, your Honor.

* * * * *

TRIAL TESTIMONY OF ALBERT TREMARI

Direct Examination

[732][1] * * * First, if you could just explain briefly what "Mechanical Systems" are.

A "Mechanical Systems" as herein indicated refers to building heating, ventilating and air conditioning systems.

Q And what does this particular requirement require? What does it set out?

A Well, Paragraph (a) relates to: "The mechanical system shall be tested, balanced and operated to demonstrate the installation and performance of these systems"—that it conforms to the requirements of these standards.

After an installation is installed or an equipment system, or what have you, after that's installed, it is common practice and accepted practice to have the system tested and balanced to see that it will, indeed, you know, heat and cool and ventilate properly.

This would entail setting the dampers in the proper position, making sure that the fans operate, that you have power up to your equipment so that the fans can operate, so the pumps will operate, and your valves are in the proper opening and closing positions and that you are getting the necessary flow rates through your piping system, you are getting the necessary air, you know, through your duct system and the air coming out through the diffusers and being supplied into the room and exhausted out through the registers from the room and [733] that the system is, indeed, exhausting and supplying, you know, the proper quantities.

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[1] Numbers in brackets refer to the Court Reporter's original pagination of the Transcript of Proceedings.

Q Mr. Tremari, with respect to—

MR. GILBERT: Your Honor, I object. I have to object to this whole line of questioning.

The issue in this case is whether these particular provisions are medically necessary for the performance of first and early second trimester abortions. Mr. Tremari is an expert engineer and we are not quarreling with that, and I am sure that he could explain what all of these different provisions mean but for us to sit here while he goes through what each of these provisions means does nothing to help us in this case or to help you in determining what is appropriate.

If he is prepared to testify as to whether these things are necessary for the performance of first and early second trimester abortions he should testify to it but to go ahead and run through them one by one, as to what an electric and mechanical engineer—

THE COURT: Well, you are saying you don't believe that this is relevant?

MR. GILBERT: Not only that it is not relevant—

THE COURT: And I take it that you are going to be tying this into your defense?

MS. STEVENS: Yes, your Honor.

THE COURT: I take it that there is a purpose for [734] asking all of these questions?

MS. STEVENS: Yes, your Honor.

THE COURT: All right. I will accept your representation and let you put your case in as you wish.

I will overrule the objection.

MS. STEVENS: Thank you.

THE COURT: And permit you to proceed.

BY MS. STEVENS:

Q Mr. Tremari, just briefly on Subsection (b), is that something that is standard practice?

A That is standard practice also.

Q All right. Now, if we could move to 205.1520 and we will just pick out certain subsections and we don't have to go through them all. We won't have to read all of them.

Subsection (a) dealing with insulation, are those standard requirements?

A These are general standard requirements, yes.

Q Would you expect to find similar insulation requirements in other—in certain buildings?

A Yes.

Q In what types of buildings would you find these requirements in?

A Offices, educational facilities, health facilities.

Q Would you find them in physicians' offices?

A In a physician's office, too.

[735] Q Would you find them in your home?

A Yes.

Q All right. Now, if you would now look at 205.1520(c), what is meant by the term "Exterior vapor barrier"?

A Well, in cold water piping systems the cold water pipe is insulated and a vapor barrier is provided as an exterior cover around the insulation. The purpose of that is to prevent condensation to occur on the surface of the insulation material itself and from penetrating into the insulation. Also to prevent—or from dripping down, you know, onto the exteriors, you know, into the room itself.

Q Okay. Thank you.

Now, if you would also look at 1520(d), and there is another reference to the National Fire Protection Association.

A Yes.

Q That "flame spread rating and smoke develop rating, are those standard requirements in buildings?

A These are standard requirements of buildings typically stipulated by the various building codes.

Q And this is a standard requirement that might be found in a physician's office?

A Yes.

Q Okay. I would like to refer you to 205.1530.

A All right.

Q And if you would look at the section—well, look at [736] both Subsection (a) and Subsection (b).

A Yes.

Q Are these requirements with regard to steam and hot water systems, are these unusual requirements?

A They are not unusual.

Q Would you consider them good engineering practice, to have these requirements?

A Good engineering practice, and, in fact, the Hydronics Institution—the Hydronics Institute has recognized—is recognized as a standard-making organization for the purpose of rating boilers and heaters.

Q Mr. Tremari, if we could then turn to 205.1540(a).

A All right.

Q And if you would—well, excuse me. If we could go to 205.1540(f).

A Yes.

Q There is reference in here to the ASHRAE standards in the whole section, isn't that correct?

A Yes.

Q And that is the ASHRAE organization that you testified to earlier?

A Yes.

* * * * *

Cross-Examination

* * * * *

[747] * * * Q When you answered the question last week when I asked you if you had—

A From a medical point of view, no.

Q You understand that an ASTC, or an Ambulatory Surgical Treatment Center, you understand it to be comparable to a medical center that incorporates delivery-type rooms and operating-type suites, is that correct?
A That is correct.
Q And the basis of your understanding of that definition is from your conversations with the State of Illinois plus your subscriptions to American Hospital Association publications, is that correct?
A My understanding of that—I do not subscribe to the magazines. As I indicated to you, I do literature research, you know, in libraries on the subject related to interests of me, okay?
Q Is the answer that your basis for your understanding of the definition of ASTC is not based on your publications that you read relating to the American Hospital Association?
A My understanding of the definition of an ASTC is by these regulations here.
Q And from your conversations with the state, is that correct?
[748] A That is correct.
Q In the journals that you read or subscribe to, in the past few years you have read nothing about ambulatory surgical treatment centers, is that correct?
A Not specifically, no.
Q Well, Mr. Tremari, do you recall when I took your deposition last week?
A Yes, I do.
Q Do you recall that I asked you if in the journals that you read or subscribe to—
MS. KREISEL: What page is that?
MS. STEVENS: May we have the page, please?
MS. KORNFIELD: Page 8.

BY MS. KORNFIELD:
Q I asked you:
"Q Do you recall whether there have been articles written in the last few years about ambulatory surgical treatment centers in any of the magazines that you subscribe to or that you read?"
And you answered:
"A Not to ambulatory treatment centers but to clean room applications, operating room applications; in other words, problems associated with contamination of operating suites, delivery rooms, water supplies, Legionaires Disease, which is a big topic now."
[749] MS. STEVENS: Objection, your Honor. This isn't impeaching.
MS. KORNFIELD: Pardon me?
THE COURT: Well, I think that he has, arguably, testified contrary to that.
She is asking him now if that was his answer to the question previously placed to him.
I will overrule the objection and permit him to answer.
MS. STEVENS: Your Honor, that wasn't the same question.
THE COURT: Well, she has gone beyond the immediate question, as I understand it.
MS. KORNFIELD: His answer to my question included more. My question was more narrow, that is, whether his reading in the last few years has permitted him to read about ambulatory surgical treatment centers.
THE COURT: He may answer.
BY THE WITNESS:
A Not specifically.
BY MS. KORNFIELD:
Q Your review of the regulations under the Ambulatory Surgical Treatment Center Act assumed the need of a surgical suite, isn't that true?

A That is correct.
Q And, in fact, the heating, ventilating, air conditioning requirements you determined are comparable to the hospital [750] Licensing Act requirement, isn't that true?
A That is correct.
Q And you also found them to be comparable to the Chicago codes regulating hospitals, isn't that true?
A That is correct.
Q In fact, your review of Table A in the ASTC Act where you discuss the air exchange requirements, which you said differed from the ASTC Act in that the Hospital Act required 25 and the ASTC Act required 15, in fact, that is the only figure which distinguishes the ASTC Act HVAC requirements from the Hospital Licensing Act, isn't that true?
A That is correct.
Q You wouldn't find that kind of air flow requirement in an examining physician's office, would you?
A No.
Q You testified that Table A—Table A or the purpose of Table A is to prevent contamination by air, is that correct?
A That is correct.
Q But you yourself know nothing about airborne bacteria relating to first trimester and early second trimester abortions, isn't that correct?
A That is correct.
Q In fact, you testified that the ASTC Act regulations are not at all comparable to the technical requirements of physician examination-type offices, isn't that correct?
[751] A I don't believe that I said that. Would you refer to the page.
Q Isn't it true that you stated—
MS. KREISEL: Page, counsel.

MS. KORNFIELD: I am just asking a question.
BY MS. KORNFIELD:
Q Isn't it true that you stated that the ASTC regulations—
MS. KREISEL: Page?
THE COURT: Well, yes, I—
MS. KORNFIELD: Page 19.
THE COURT: If you are referring to his deposition you should give them, in advance, a page notice so that they can check what you are reading from.
MS. KORNFIELD: Okay. I will.
BY MS. KORNFIELD:
Q Did you state prior, Mr. Tremari, that:
"A So, to say that this document"—the ASTC reg's—"is comparable to the technical requirements of an examination"—
MS. STEVENS: Excuse me. What page is that again?
MS. KORNFIELD: 19.
THE COURT: Page 19.
BY MS. KORNFIELD:
Q (Reading continued:)
". . . is comparable to the technical requirements of an [752] "examination-type office is not the case at all."
A Right. And read on further, if you would.
Q The next is a question. A question from me.
A Would you read on further.
Q I have the next question, Mr. Tremari.
The filters that you referred to in Regulation 205.1540, do you recall those filters?
A Yes.
Q Didn't you testify that you can't decide filter requirements until you know the procedures performed in the rooms?
A That is correct.

Q Pardon me?
A I did not say that "until you know the procedures performed in the room," I said that you know it by the room classification.

If the room is classified as a treatment room, examination room, a procedure room or a surgery room, that tells you what kind of filter system you are going to use.

I do not have to know anything about the medical practice that occurs inside that room; all I know is what is the definition and the function of that room. It is not what goes on precisely from a medical point of view.
Q This classification of rooms according to use, are you familiar with the BOCA Classification I?
A Yes.
Q "I" for "Institutional"?
[753] A Yes.
Q Is that the classification that you used in reviewing these regulations in order to reach your opinion that they were comparable to other codes?
A Yes.
Q Mr. Tremari, are you familiar with the BOCA Basic National Building Code of 1984?
A Yes.
Q And didn't you tell me that you consulted that in arriving at your conclusion as to the appropriateness of these regulations?
A Right. Yes.
Q Are you familiar with the classification called Group B Business Buildings?
A Yes, I am.
Q Do you know that BOCA considers out-patient clinics, physicians' offices and dentist's offices to be Business Uses?
A Yes, I do.

Q And do you know that the Group I Classification that you used, and I am reading from Chapter 3 of this code, Group I Institutional Buildings—
MS. KREISEL: What page are you on?
MS. KORNFIELD: Page 51.
MS. KREISEL: Thank you.
BY MS. KORNFIELD:
[754] Q (Continuing) States—the general description is "All buildings and structures, or parts thereof, shall be classified in Use Group I in which people suffering from physical limitations because of health or age are harbored for medical care or other care or treatment or in which people are detained for penal or correction purposes or in which the liberty of the inmates is restricted" and that Use Groups I include, for example, "facilities for children, aged persons, mentally impaired and convalescence, including convalescent facilities, group homes, homes for the aged, mentally retarded care facilities, nursing homes (ambulatory) orphanages and residential care facilities" and Use Group I(2) includes "hospitals, sanitariums, infirmaries," etc.?

Are you familiar with that classification?
A Yes.

* * * * *

TRIAL TESTIMONY OF MARY JANE RAMSAY, R.N.

Direct Examination

[767][1] * * * THE COURT: * * * Can I just ask you, Mrs. Ramsay, do you do any inspection of any doctors' offices or is it only the ASTC's and hospitals—well, do you do hospitals as well?

THE WITNESS: Yes, I do hospitals. Yes.

THE COURT: Hospitals and ASTC's?

THE WITNESS: Hospitals and ASTC's and end-stage renal dialysis units but no—no doctors' offices, no.

THE COURT: I see. All right. Thank you.

* * * * *

Cross-Examination

BY MS. CHAITEN:

Q Mrs. Ramsay, I am giving you what has been marked as [768] Plaintiffs' Exhibit 10.

A All right.

Q That's the Ambulatory Surgical Treatment Center Act and Regulations.

A Yes.

Q I'd like you to turn to Section 3(a) of the act which is on, I believe, Page A-1.

A All right.

Q Can you tell me if the Illinois Department of Public Health enforces this provision as it is written?

A Just the page or the whole act?

Q Section 3-A?

A (Examining.)

[1] Numbers in brackets refer to the Court Reporter's original pagination of the Transcript of Proceedings.

They are not—it is my understanding that they are not emphasizing the area where—"medical or surgical procedures utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose."

Q How do you know that they are not enforcing this?

A I have been told that they were not enforcing it.

Q By whom?

A I don't specifically recall.

Q Was it somebody in the Illinois Department of Public Health?

A Yes.

Q Did you receive any written documents or document stating that they are not enforcing this?

[769] A I don't recall that I did.

Q Have you been instructed to inform physicians and health care providers that they are not enforcing this?

A No, I have not been instructed to inform anyone.

Q Do you know if there has been any official notice sent to health care providers?

A I don't know of any notice one way or the other.

Q So, the Illinois Department of Public Health hasn't published the fact that they are not enforcing this provision?

MS. KREISEL: Objection, your Honor. The witness testified that she didn't know.

THE COURT: Well, I will overrule the objection and permit counsel to ask a sort of a summing up question, which I think that that was intended to be, and then we will be sure what the answer is.

You may rephrase the question.

MS. CHAITEN: All right.

BY MS. CHAITEN:

Q So, there hasn't been any official notice given to your health care providers?

A I do not know what has been sent from Springfield or what has not been sent.
Q Okay. Can we turn now to Section 205.740.
A All right.
THE COURT: What was that number again now?
[770] MS. CHAITEN: 205.740.
THE COURT: Okay. Thank you.
BY MS. CHAITEN:
Q Mrs. Ramsay, is this provision of the ASTC regulations enforced by the Illinois Department of Public Health?
A We are not enforcing the last paragraph which says that abortions shall not be performed on those patients whose gestation exceeds 12 weeks.
Q And how do you know that you aren't to enforce this provision?
A I again was told from Springfield.
Q How were you told? Was there a written document?
A I don't remember.
Q And were you told to inform health care providers that this provision isn't being enforced?
A I was not told one way or another.
Q Okay. Do you know if there is any official notice being sent to providers about whether or not this provision is being enforced?
A No, I do not know what has been sent or has not been sent from Springfield.
Q Do you provide informal information to providers who ask?
A Yes, I do.
Q Does the IDPH enforce this provision during any part of the second trimester?
[771] A No, not that I am aware of.
Q Do you specifically tell providers that they can do second trimester abortions?
A No.

Q Okay. Let's turn now to Section 205.760.
A All right.
Q Mrs. Ramsay, is this provision being enforced by the Illinois Department of Public Health?
A No, it is not.
Q And how do you know that?
A Again, I was informed from Springfield.
Q Do you remember in what form you were informed?
A No, I don't.
Q Is there an official notice being sent to your health care providers?
A I don't know of any official notice.
THF COURT: Could you give me that number one more time again.
MS. CHAITEN: Yes. That was Section 205.760, your Honor.
THE COURT: All right. Thank you.
BY MS. CHAITEN:
Q Are health care providers informed of the nonenforcement of this provision informally?
A Yes, they are.

* * * * *

[776] Q Sure. Is the skill of the physician very important to the quality of care that a patient receives?
A Yes.
Q Okay. And the physician's integrity is also important, isn't that true?
A Yes.
Q Okay. But these regulations don't regulate the skill or the integrity, is that correct?
A That is correct.
Q So, then, you would agree that the fact that a facility is licensed under the ASTC Act doesn't assure that the quality of services of procedures performed in the facility will be of a high standard, is that correct?

A I would say that the rules and regulations help to regulate the health and welfare of the patients in the facility.

Q Mrs. Ramsay—

MS. KREISEL: Objection. The witness wasn't allowed to finish her answer.

THE COURT: All right. If you haven't completed your answer, go ahead and complete it.

BY THE WITNESS:

A The regulations help to protect the patient, the health and welfare of the patient.

I guess that that's all. Along with the skill of the physician.

* * * * *

TRIAL TESTIMONY OF MARY LLOYD LOWE

Direct Examination

[652][1] Q In what capacity?

A I am Deputy Chief Counsel.

Q How long have you been with the department?

A Five years.

Q Do you know, Ms. Lowe, how many licensed ambulatory surgical treatment centers there are in Illinois?

A There are 42.

Q And of the 42 how many of those facilities have indicated that pregnancy terminations would be performed?

A 22.

MS. KREISEL: I am handing the witness what has been marked Defendants' Exhibit No. 2.

THE COURT: All right.

BY MS. KREISEL:

Q Do you recognize that document?

A Yes.

Q What is it?

A It is a memorandum from Michael Anderson to William L. Kempeners and three other people dated June 29, 1981.

Q Do you have personal knowledge of this memorandum?

A Yes.

Q What is the subject matter of the memorandum?

A The ASTC Act.

Q Now, am I correct to say that the subject matter of the memorandum is also the Marcowitz case?

[653] A Village of Oak Lawn vs. Marcowitz, yes.

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[1] Numbers in brackets refer to the Court Reporter's original pagination of the Transcript of Proceedings.

Q Okay. Did the Illinois Supreme Court decision in that case have any effect on the department's enforcement of the Ambulatory Surgical Treatment Center Act?
A Yes.
Q And what effect was that?
A As a result of the decision, the department no longer considered facilities in which single abortions were performed to be subject to licensure.
Q And does this memorandum reflect that position?
A Yes.
Q And is that still the department's policy?
A Yes.
Q Do you foresee any change in that policy?
A No.
Q Did the department promulgate a regulation to that effect, reflecting the policy of enforcement of that portion of the act?
A No.
Q Why not?
A The department doesn't have authority to promulgate regulations which contradict a statute.

* * * * *

[658] * * * Q And which one was that?
A The Akron decision.
Q Okay. And how did that relate to the Poe—the section of the ASTC regulations which had been the subject matter of the Poe case?
A I believe that it merely reaffirmed previous positions.
Q And is your belief reflected in that memorandum?
A Yes.
Q And does that reflect the department's policy as to that section of the regulations?
A Yes.

MS. KREISEL: Your Honor, I move for the admission of Defendants' Exhibits numbered 3 and 4.
THE COURT: Any objection?
MR. GILBERT: No objection.
THE COURT: They will be received in evidence at this time.
(Defendants' Exhibits 3 and 4 received.)

* * * * *

BY MS. KREISEL:
Q Are you familiar with the Charles vs. Carey case, the [659] 1983 District Court version?
A I believe so.
Q Did the permanent injunction which was entered in that case have any effect at all on any of the Ambulatory Surgical Treatment Center regulations?
A Yes.
Q And what effect was that?
A I believe that that decision enjoined as unconstitutional Section 10 of the abortion law which was the reporting requirement.
Q And what effect did that have on the ASTC reg's?
A The regulations requiring the reporting of abortions has not been enforced since that time.
Q And is there any plan to enforce that provision in the future?
A Not that I am aware of.
MR. GILBERT: Your Honor, may I ask counsel, are you referring to 205.760?
MS. KREISEL: Yes. For the record, 205.760.

* * * * *

Cross-Examination

* * * * *

[661] * * * Q And who violates any other provision of the act?

Basically, any provision of this act subjects someone to criminal penalties, is that correct?

A That appears to be what it says.

Q Now, you mentioned—well, first let me get those documents.

The Defendants' Exhibit 2, do you have that in front of you? That's the June memorandum, the Michael Anderson document?

A No, I don't.

MR. GILBERT: Do you have a copy of that exhibit that you can give the witness?

BY THE WITNESS:

A All right. Now I do have it.

BY MR. GILBERT:

Q And that regards the Marcowitz decision; are you familiar with that decision, being a lawyer?

A Yes. Yes.

Q Now, the Marcowitz decision didn't involve the Ambulatory Surgical Treatment Center Act or its regulations, did it?

A No.

Q It involved an ordinance of the Village of Oak Lawn, isn't that correct?

A Yes.

[662] Q And there is nothing in that decision that involves the Ambulatory Surgical Treatment Center Act in any manner whatsoever, isn't that right?

A I haven't read the decision for some time.

Q Well, do you know whether the Department of Public Health or any agency or representative of the State of Illinois was a defendant in that action?

A No, I don't.

Q Do you think that I am wrong if I say that no state agency or official or representative or agent or the state itself was a defendant in that case?

MS. KREISEL: Objection. She just said she has not read it in a while, she didn't know.

She shouldn't have to take counsel's word for it.

THE COURT: Yes, I mean, she said she does not know. And I can take, certainly, judicial notice of the decision. I have a copy of it right here in this file. Or on this pile here.

MR. GILBERT: Okay.

THE COURT: I think that the decision does cover that point, doesn't it?

MR. GILBERT: It does and I would ask the Court to take judicial notice of that, that it does not involve the State of Illinois in any way.

THE COURT: I have got the decision right here. Just [663] a second. Just as I have Charles vs. Carey and others.

Yes, it is just—the two parties are the Village of Oak Lawn as appellant vs. Stewart Marcowitz as appellee. And they show no amicus curiae or anything else. It shows the attorneys representing the individuals, or the Village and the individual.

BY MR. GILBERT:

Q Okay. Turning again to Defendants' Exhibit 2, the memorandum from Michael Anderson, were you working in the department at that time, by the way, in '81?

A Yes.

Q Did you have any role in the drafting of this memorandum?

A Yes, I did.

Q Did you write it?

A No, I did not.

Q And the last line there says: "Surveyors and members of the ASTC Advisory Board should be so notified."

Well, let me read that whole paragraph, it is hard to take that sentence out of context.

The last paragraph says: "Accordingly, from now on in all licensure and enforcement proceedings an 'ASTC' is officially only those facilities, 'devoted primarily to the performance of surgical procedures'."

It goes on to say: "Surveyors and members of the ASTC Advisory Board should be so notified."

[664] Do you know if surveyors and members of the ASTC Advisory Board were so notified?

A No.

Q You have no knowledge of whether they were or not?

A No.

Q Are you aware of any other documents that reflect any change in enforcement by the department with regard to this particular provision that is mentioned in Defendants' Exhibit 2, which involves the definition of an "Ambulatory Surgical Treatment Center"?

A No.

Q There has been no change in the act, has there?

A No.

Q The act still says that you can't perform even one abortion outside of an ambulatory surgical treatment center?

MS. KREISEL: Objection. That is not what the act says. That is a paraphrase.

BY MR. GILBERT:

Q Is that paraphrased—do you consider that paraphrase accurate?

A Yes.

Q And there is no regulation that has been promulgated for the public to read that suggests that that portion of the act isn't being enforced?

A No.

[665] Q And there have been no notices, written notices, sent to anyone covered by the act or provided—

A I don't know.

Q You aren't aware of any that have been sent?

A I don't know.

Q And I take it that you aren't aware of any persons who have ASTC licenses or any physicians who hold licenses who have been informed orally about this change in licensure and enforcement?

A Yes, I am.

Q Oh, you are aware?

A Yes.

Q What are you aware of?

A I have on various occasions received phone calls of inquiry regarding that language and I have responded to them.

Q And you have told them that that language is no longer being enforced, is that right?

A That is correct.

Q But until a physician or someone else who runs an ASTC who wishes to perform abortions calls, they wouldn't know, would they?

A I don't know.

Q Well, you wouldn't tell them any other way except upon inquiry, is that right?

A That is correct.

[666] Q Now, you testified, I believe, on direct examination that now the ASTC Act doesn't apply to facilities in which single abortions are performed, isn't that your testimony?

A Yes.

Q Does the ASTC Act now enforced to apply to facilities in which two abortions are performed?

A May I explain?

Q Certainly.

A We enforce the act as regards places devoted primarily to the maintenance and operation, primarily to surgery—
Q Okay.
A —and, assuming—
Q Well, does that—
A —that a place did only two abortions and that was all that they did, yes, the act would apply.
Q Well, what about a physician who performs—or who has a regular obstetrical and gynecological practice and performs ten abortions a year, would that physician's office have to be an ASTC?
A It would depend upon whether his practice was devoted primarily to surgery.
Q I see. Well, what if that physician does a little bit of cryosurgery in his office as well as some, oh, diagnostic D&C's and does some abortions and he does, oh, 100, 150 of those procedures a year, would that be covered?
[667] A It would depend—

THE COURT: She has got to go back to "primarily."

Why don't you ask her what is her understanding of the word "primarily". I mean, as to what that means.

BY MR. GILBERT:
Q Can you answer that question?

THE COURT: Is it 51 percent or what—can you put it in the form of a figure?

THE WITNESS: Yes. A majority of patient visits, being surgical or surgically related.

BY MR. GILBERT:
Q Okay. Is that your interpretation of what "primarily" means?
A Yes.
Q Is it written down somewhere?
A I believe it is in a court decision from the First District Appellate Court.

Q What is that case?
A The Illinois Appellate Court, First District.
Q What is that decision?
A I believe that the caption is "People ex rel. Kempeners vs. Stuart Marcowitz."
Q I see. Now, has that interpretation been written up in any rule of the department?
A No.

* * * * *

[673] * * * Q And the Ambulatory Surgical Treatment Center licensing board never promulgated any policy regarding those various interpretations by the department, did they?
A Not that I am aware of.
Q And there are no rules or regulations which reflect those interpretations, are there?
A Not that I am aware of.
Q And being interpretations of the department, those are just interpretations by the people who are in the department at the time that they are made, isn't that correct?
A I believe that that is correct.
Q And if the people should leave and new people should come into the department, couldn't those interpretations change?
A I believe that that is possible.
Q And isn't it also possible that people could change their minds and decide that the interpretation that they made before is no longer accurate?
A That's a possibility.
Q Now, you mentioned in regard to the Defendants' Exhibit 3 that 7.04.01 was the original number that was covered in the Poe—that it was your interpretation that the Poe decision [674] affected?
A Yes.

Q In December of 1982?
A Yes.
Q But the regulations were recodified after that time, isn't that right?
A Yes.
Q That meant that the numbers were changed and a new set of regulations was issued, is that right?
A The number and the format content does not change upon codification, per se.
Q All right. But you go through the, oh, the Administrative Procedure Act procedures to recodify a set of reg's, don't you?
A Yes.
Q And the formal procedures for rule making and all?
A Yes.
Q And, indeed, since that time, since 1982, and, in fact, since—yes, since—let me see if I have got the right time—yes; since 1982 there have been changes in some of the regulations, haven't there been, I mean, in the ASTC Act? Substantive changes?
A I believe so.
Q Substantive changes?
A I believe so.
Q Which involved the somewhat burdensome process of going [675] through the Administrative Procedure Act, of submitting the proposed rules to the Committee on Rule Changes and having the director sign off on the rules and having the public comment and notice period and the two or three publications, is that an accurate paraphrase of the system?
A Briefly stated, yes.
Q Briefly stated?
A Yes.
Q It is burdensome but you have gone through it and the department has gone through it on more than one occasion with regard to the substantive rules since 1981 and 1982, right?

A I don't know how many times.
Q It has been a lot more than one occasion, isn't that right?
A I don't know.
Q Oh, you are not aware at all of that?
You just mentioned before that you are aware of some changes?
A Yes, but I don't know how many times.
Q I see. Is it more than one?
A I don't know.
Q Okay. Fine.
Anyway, they have gone through that but—and also I notice, if I have got it here. One moment.
Let me show you Exhibit 10 here, it is the first [676] page of the rule part; it says that these were codified June 14th, 1984.
Are you familiar with the codification of those rules at that time?
MR. GILBERT: This is Exhibit 10, counsel.
BY THE WITNESS:
A Yes.
BY MR. GILBERT:
Q And to do that one had to go through the rule making process?
A I don't know the process involved in codification.
Q But, despite all of those different rule changes, or the fact that there were rule changes and codifications, Section 205.740 remains on the books, doesn't it?
A I believe so.
Q And so does Section 205.760?
A I believe so.

* * * * *

TRIAL TESTIMONY OF MARGARET MOE

Direct Examination

[550][1] * * * Q As a part of your gynecological services do your physicians insert IUD's?
A Yes.
Q And this is performed in the clinic?
A Yes.
Q Do you perform abortions at your clinics?
A No.
Q How many patients are seen at your clinics when you combine the two together in an average week?
A Approximately 400.
Q Do you know about how many come in for family planning services?
A About half of that, about 50 percent.
Q Do you know about how many requests you receive, and when I say "you" I mean your clinics, receive in the course of, well, in each week, how many requests you receive from your patients for abortion services?
A From our actual patients, approximately 60 per week between the two facilities.
Q And does this vary from time to time?
A It is always going to vary, particularly when you are dealing with teenagers because they have certain times of the [551] year when they are more prone to become pregnant and so we have some weeks that are considerably higher; it is usually six to eight weeks after prom and usually six to eight weeks after Christmas.

[1] Numbers in brackets refer to the Court Reporter's original pagination of the Transcript of Proceedings.

Q In the course of running your clinics you had said that you do counseling and that you do abortion referrals?
A Yes.
Q Do you also direct your staff as to counseling progams?
A Yes.
Q Do you or your staff travel to the facilities of abortion providers to examine them before you make referrals?
A Absolutely.
Q And why do you do that?
A Because I have to be sure that whenever we make a referral for anything that we are sure of the competency of the organization, that the people who are in that organization are going to take care of the women the way we would like them taken care of, and that includes their emotional support as well as their health support.
Q Do you have a hospital in your community that performs first and early second trimester abortions?
A I don't know about second trimester or early second but I know that they perform first trimester.
Q Do you refer patients to that hospital?
A No.
[552] Q Why do you not refer them?
A Because it triples the cost for the patient.
Q Are there any other reasons?
A Well, it is a hospital environment and they are usually afraid; it is local, and they are going to be subjected to staff that has been assigned duty as opposed to, you know, being on duty in this type of a case. They are not just going to do one termination after another, I mean, they may do a termination and then it may be a woman who has had a miscarriage who they are doing a D&C on and there is no separation there and so it is very uncomfortable for the woman, and I am sure that it is uncomfortable for the staff, too.

Q Do you ever handle special counseling problems for abortion referrals?
A Yes. Yes, I do.
Q And what would you consider to be a "special problem"?
A Well, they come in many packages; it could be a very young person where I really am not sure that they understand what is going on and it may in fact be her parents who are offering some very grave concerns or some fears that they have about procedures or, "Where is my doctor going to go? What is going to happen?"

It could be an older woman. It is not unusual for me, that is, for me personally, to get into counseling women [553] 50 to 55 where they have found themselves pregnant throughout what they thought was menopause and this is what it has turned out to be and this is very stressful for the women of that age. They frequently look at me and say, "What am I to do? My youngest is 32."

THE COURT: Oh, boy!

THE WITNESS: Yes. It is really hard.

BY THE WITNESS:
A And for me they are very special cases and they need to be treated sensitively and they need to know that everything is going to be okay for them.
Q You have, then, daily familiarity with women as they seek counseling or attempt to implement a decision to receive an abortion, do you?
A Yes.

MS. KORNFIELD: At this time, your Honor, I tender Ms. Moe as an expert in the area of women's health care and family planning.

THE COURT: All right. Any objection?

(No response.)

All right. She will be considered as an expert for evidentiary purposes.

* * * * *

[555] * * * BY MS. KORNFIELD:
Q Starting with the Medical Practice Act, Ms. Moe, how has that burdened women seeking abortions?
A Well, it has burdened women who come to my facilities because I have had doctors who have been willing to perform terminations but due to that act they have been unable to.
Q What will happen if they perform abortions?
A It is my understanding that they will lose their licenses in the State of Illinois.
Q Is that—

MS. KREISEL: Objection.

MS. KORNFIELD: It is her understanding.

THE COURT: Yes. I will overrule the objection and permit it to stand.

BY MS. KORNFIELD:
Q Do they consider the loss of their licenses to practice medicine a serious—

MR. FLAHAVEN: Objection.

MS. KREISEL: Object.

MR. FLAHAVEN: Object as to what other people think.

THE COURT: Yes. I will sustain the objection as to that.

BY MS. KORNFIELD:
Q Ms. Moe, the physicians that you employ who are willing [556] to perform abortions, have they performed them in the past?
A Yes, they have.
Q And are they competent and willing to perform them today?
A Yes, they are.
Q Do you know of other physicians in the State of Illinois, specifically, in Cook, Kane and DuPage County, who

would be willing to perform abortions except for these three acts?

A Yes.

MR. FLAHAVEN: Object. It has to be based on hearsay, your Honor.

MS. KORNFIELD: Judge, she is a medical professional.

THE COURT: Well, it isn't necessarily based on hearsay and I take it that you are—well, you have the right of cross-examination to bring out the details but it seems to me that there has been enough indication of background knowledge on her part to have a sufficient foundation.

I will overrule the objection and permit the answer to stand.

It can always be subject to a motion to strike should that turn out to be appropriate.

BY MS. KORNFIELD:

Q Ms. Moe, are you registered with the Department of Registration and Education?

A Yes, I am.

Q Have they ever contacted you to tell you that the Medical [557] Practice Act is not enforced insofar as it relates to the performance of abortions being required in ambulatory surgical treatment centers or hospitals?

MS. KREISEL: Objection, your Honor. The question doesn't even make any sense. Why would the Department of Registration and Education contact a nurse about something in the Medical Practice Act?

MS. KORNFIELD: She is registered with the department.

THE COURT: Well, it may not have much weight but it seems to me that it is sufficiently—that it is possibly sufficiently relevant.

I will overrule the objection and permit her to answer.

A No, they have not.

BY MS. KORNFIELD:

Q Do you have any information that any of your physicians have been contacted by the Department of Registration and Education to the effect that they are not enforcing the Medical Practice Act?

MR. FLAHAVEN: Objection. Hearsay.

MS. KORNFIELD: I asked if she had information.

THE COURT: Yes. I will overrule the objection and permit her to answer.

BY THE WITNESS:

[558] A No, they haven't.

Usually what happens is that the physicians that I have employed will keep all communications coming to me as it pertains to anything, whether it is a change in treatment of diseases that is new and upcoming or changing laws or rules, or even newspaper items. We always have that coming into the clinics so that everybody can get to share what is going on.

BY MS. KORNFIELD:

Q Ms. Moe, have you ever contacted the Illinois Department of Public Health to inquire as to the procedure for obtaining a license for an ambulatory surgical treatment center?

A Yes, I have.

Q Do you recall when you first contacted them?

A I believe it was around approximately 1974.

Q Do you recall whom you contacted there?

A It was a Mr. Bilstein, was the name of the person I spoke to.

Q Did you contact him in person or on the phone?

A I have spoken to him in person and over the phone.

Q Do you recall at that time when you contacted him in 1974, whether it was in person or over the phone?

A On the phone.

Q Now, why did you call him?
A Because I was interested in providing the services and I [559] needed to find out what was required to allow us to do that.
Q And when you say "services" do you mean abortion services?
A Abortion services. Yes.
Q What did Mr. Bilstein tell you?
A He told me that I needed a license and he sent me a copy of the rules and reg's.
Q Did you do anything further as to becoming licensed to be an ASTC?
A In 1974 I did not, it was just too overwhelming, they wanted so much.
Q Can you explain that answer further.
What did they want that you found "overwhelming"?
A Well, the building requirements were just amazing; air exchanges that really weren't necessary, and so on.

I wasn't going to be performing major surgery, I just wanted to perform terminations as to pregnancies and the air exchanges, the excessively wide corridors, which, you know, most doctors' offices don't have.

Now, we have wide corridors in our facilities, by medical office standards, but they weren't as wide as they were requiring.

We have never had a problem in getting stretchers, etc., either in or out of them. We do occasionally have that.
Q You have testified that you spoke to Mr. Bilstein on a [560] couple of occasions—
A Yes.
Q Do you recall specifically which regulations he sent you in 1974?
A The Ambulatory Surgical Treatment—the Ambulatory Surgical Care Licensing Act, I believe, is what he sent.

Q Did you speak with Mr. Bilstein after that time?
A Yes, I have.
Q Did you ask him again if you needed a license to be an ASTC?
A Yes.
Q What did he tell you?
A That, yes, I did.
Q And did you go any further with that at that time?
A I had looked—I had gone to a building consultant who built medical facilities and he told me I was basically being requested to build a hospital and I simply could not afford that because it is a business, you know, you have to charge those costs off to your patients and I certainly was not willing to do that. I certainly wasn't willing to go to that extent.
Q Do you recall what he told you it would cost?
A I don't recall. I am sorry.
Q You just recall—
A That it was a lot.
[561] Q Were you able to afford it at the time?
A Absolutely not.
Q Are you familiar with the Certificate of Need requirement of the Health Facilities Planning Act?
A Yes.
Q Do you consider that requirement to be a burden to either you or your patients? To either you or your women patients?
A Yes, it is a burden because you have to have a Certificate of Need before you can build an ambulatory surgical care center and, unfortunately, in our area you won't get that because hospital censuses are down and we have vacant hospital beds and there are some surgical treatment centers that just do surgery and so there really is not a documented need.

Q Has anyone attempted to get a Cetificate of Need in your community?
A Yes, I am aware of someone who was starting to make that attempt for an alternative birthing center.
Q Has anyone attempted to get one who was turned down?

MS. KREISEL: Objection. That calls for hearsay, Judge.

THE COURT: Yes. I don't know what foundation or knowledge she would have or how she would have arrived at that.

* * * * *

[566] * * * BY MS. KORNFIELD:
Q And, as a result of speaking with this individual at HSA, Ms. Moe, what did you decide to do with respect to obtaining a Certificate of Need?
A Not to proceed.
Q Now, are you familiar with the burdens encountered by women who seek abortions in Illinois?
A Yes, I am.
Q What is one of the barriers that they face?
A The main barrier that they face is not to be able to seek abortions within their own communities.

It is an emotional trauma for them, to begin with, and it is a big decision for them to make and we burden them by making them travel long distances from home.

Frequently, and from my experience with my patients, although I cannot speak for all women in Illinois, but from my patients, a large majority of them have no means of transportation.
Q Do you know what percentage of the women at one of your [567] clinics in Elgin do not have personal transportation?
A About 90 percent.
Q And your clinic in Palatine?

A Well, it is always hard to—I'd say about 50 percent in Palatine, approximately.
Q All right. So, this burden, then, as to the delay that they encounter, do you know approximately about how far they have to travel since they cannot obtain them locally?
A It depends upon where they are living but, on an average, it is 50 miles to 100 miles on an average, it is 50 miles to 100 miles, depending upon—because we pull patients as far away as Wisconsin, the Wisconsin border.
Q So, for those patients, it would be burdensome?
A Yes.
Q What sort of public transportation do you have in your communities?
A Well, we have one train that goes into Chicago.
Q Do you have any buses?
A We have no buses. Or at least certainly that don't—they don't go by the facilities there although there might be a RTA that picks up at railway stations to go out to the communities but not that go directly. And not that go across the state.
Q Are you aware of any ASTC's in your community?
A There is an Ambulatory Surgical Treatment Center by the [568] Northwest Community Hospital but that does not perform terminations.
Q Do you know where the nearest facility is that performs terminations where you would recommend a patient—where you would refer a patient?
A It would be in Chicago, on Peterson Avenue.

MR. KEMMER: I am sorry, I didn't hear the end of your answer.

THE WITNESS: Peterson Avenue.

MR. KEMMER: Oh, Peterson Avenue. All right. Thank you.

BY MS. KORNFIELD:
Q How do your patients get to your clinics?
A Well, they get rides from friends, but many of them walk. And that has always been frustrating to me because I have had youngsters walking in literally delivering babies and they have walked for 30 minutes to get to the clinic.
Q Have you counseled your patients as to—how do you counsel them in order to prepare them to travel to Chicago to receive an abortion?
A Well, my first preparation for any woman who is contemplating termination of pregnancy is to be sure that this is a decision that she is making freely for herself with all of the facts.

Once we have gone through that portion of it I then [569] would like to talk to her about the actual procedure, explaining to her step-by-step what she can expect and what each individual probably expects of her, you know, as to the fact that she would get some preparation at the facilities; there would be people talking to her, the lab work, and so on. As to the actual procedure, I like to take her step-by-step to show her, visually, the instruments that will be used so that she won't be afraid or made afraid by this.

But then the last part is always the hardest part; I have to talk to her about preparation for crossing picket lines, to be careful if she is in a car because they—they might be better advised to park several blocks away and walk into the facility from there because license plate numbers are taken and they are traced and they will receive harassing phone calls.
Q Have some of your patients been harassed in this way?
A Yes, they have.
Q All right. Please continue.

A The other part is, you know, if you have a woman who has children she has to get baby-sitting for that child; if she was in her community she could easily find sitting for a couple of hours but when she goes to Chicago she has to find a baby-sitter to sit for the entire day.

She has to have somebody to accompany her because you can't expect a woman who has gone through this or is [570] going through this to travel on a train or to drive herself, not that amount of miles, and she certainly can't do it comfortably and it is important that we feel secure that our patient is going to be comfortable.

So, she has to get herself cleared from work if she is a working woman or perhaps a friend will have to lose some time from work, all of this.

So, this keeps adding to the burden; it adds financially, it adds emotionally and it causes a tremendous amount of delay. She has to coordinate all of these things.
Q And when she loses—have you had patients who, when they have had to take time off from work, have lost wages as a result of that?
A They lose wages and they have, occasionally, lost jobs.
Q If you were able to perform pregnancy terminations at your clinic, would you be able to have, for example, evening hours?
A Absolutely. We are already open four evenings a week.
Q Do our patients then have to return to Chicago for checkups or follow-up visits?
A The facilities ask that the patients return to their facilities because it is a part of their service but our patients do not, they come to our facility for that follow-up care.

* * * * *

[572] * * * BY MS. KORNFIELD:
Q Ms. Moe, have you had patients whose delay in obtaining abortions as a result of the burdens have required second trimester abortions instead of first trimester abortions?
A It has required that but frequently they will not proceed with the second trimester, what will happen is that they will have the baby.
Q Yes. And have you had patients whom you have had to send out of state because they were far enough along in their pregnancy?
A Yes. Outside of early second trimester, we send all of our second trimester out of state.
[573] Q And is that out of state facility a physician's office or a hospital-like clinic?
A Physician's office.
Q Do you have any knowledge as to what the cost of the abortion is once you figure in the actual cost of the abortion and then you add in the other burdens that you were discussing; the lost wages, the travel, etc.?
MS. KREISEL: Objection. Foundation.
MS. KORNFIELD: I have asked if she has any knowledge.
THE COURT: Well, I—
MS. KORNFIELD: I could ask additional questions, if you would like, your Honor.
THE COURT: I will sustain the objection for lack of foundation.
BY MS. KORNFIELD:
Q Ms. Moe, do you do post-abortion counseling?
A Yes.
Q Do your patients talk to you as to the burden that they encounter?
A Yes.

Q Do they tell you how much money they have lost as a result of missing work?
MR. FLAHAVEN: Objection. Hearsay.
MS. KREISEL: And leading.
MR. FLAHAVEN: That's not a state of mind.
[574] MS. KORNFIELD: The basis for her opinion—
THE COURT: Well, I think that the state of mind that you are seeking to bring out is whether an individual, or a woman, feels burdened and it seems to me that, without admitting it for the truth of the matter asserted, it seems to me it should be—that statements of the patient should be admissible to show the patient's state of mind, that is, whether the patient feels burdened by the requirements that have been previously testified to and, on that basis, I will overrule the objection and permit the witness to testify.
BY MS. KORNFIELD:
Q Do you recall the question or would you like it read back?
A Would you read it back, please.
MS. KORNFIELD: If you would.
(Question read.)
BY THE WITNESS:
A Yes. Some will approximate a dollar amount and some will just talk about lost days work or other people losing days of work.
It is not unusual for it to have at least doubled and, sometimes, tripled as to the cost of the termination itself by the time that all of these factors are added in.
BY MS. KORNFIELD:
Q Do these women patients consider that to be a burden?
[575] A Absolutely. They have often had to borrow the money to take care of this.

Q Do you consider the procedure of first trimester and early second trimester abortions to be a part of health care?
A Oh, absolutely.
Q The provision of first trimester and early second trimester, you consider that to be a part of health care?
A Absolutely. Yes.
Q Can you explain why that is a part of health care.
A Well, it is the women's emotional well-being as well as her physical well-being and it is all part of the whole gynecological area and here I am saying that I am providing for women's health and I do everything from, you know, the onset of the period through menopause, with this one service that I am not able to provide.
Q In your profession, do you know of any medical reason why abortion facilities must be singled out?
MS. KREISEL: Objection, your Honor.
THE COURT: Objection overruled. She may answer, if she can.
BY THE WITNESS:
A I do not know of any medical reason why it should be singled out or put into specific licensing.

* * * * *

[577] * * * BY THE WITNESS:
A My opinion is formulated from the patients who seek need in my facilities and we do have approximately 60 women a week of our own, but, added to that, I receive telephone calls at both facilities from other women seeking these services; they have had their pregnancies confirmed by doctors' offices and, frequently, they are very distressed, particularly when they learn that they have to leave the community.
We are frequently asked, "Why can't you do it? Why can't we do it here?"

* * * * *

BY MS. KORNFIELD:
Q Ms. Moe, have you recently contacted the Illinois Department of Public Health?
A Yes, I have.

* * * * *

[580] * * * Q Have you had any recent conversations with the Illinois Department of Public Health?
A Yes.
Q When was this conversation?
A Monday morning.
Q Do you recall about when Monday morning?
A At 9:00 o'clock, a.m.
Q And whom did you call?
A I called the general number of the Illinois Department of Public Health.
Q Then what happened?
MS. KREISEL: Objection. Foundation.
[581] THE COURT: Well, I would require that you lay the foundation and so, to that extent, I will sustain the objection.
BY MS. KORNFIELD:
Q Ms. Moe, why did you place this telephone call?
A I was just interested to know what it was that they were still saying about the Ambulatory Surgical Treatment Center Act. The licensing act.
Q Had you heard anything to the effect that their position had changed?
A No, I had not. I don't know why I did it. I just got up and I just questioned in my own head, "I wonder what they are saying today?"
MS. KREISEL: Your Honor, we are going to have to object. If it is anything pertaining to this case a plaintiff should not be calling a defendant.

MS. KORNFIELD: Well, certainly the Canons of Ethics prohibit attorneys from contacting the other parties—is that what you are referring to?

THE COURT: Well, I am going to say that if there is no implication that she either notified her counsel or had realized that there was any legal, any ethical-legal prohibition against contacting a public office—I am not going to bar her testimony on that basis. I do think that this is a special circumstance where you do have an on-going public office and an on-going enforcement of the existing law.

[582] I will, on the other hand, say that it is not desirable to have parties going behind attorneys' backs and contacting other parties although usually what the concern is is that you are going to be having a party try to do something or get an admission, or something, which would be a form of trickery or taking advantage of the lack of knowledge of a party but here you are dealing with a public agency who, presumably, says the same thing to any citizen who calls and asks the same question or questions.

So, I don't see the danger here of prejudice and, on that basis, I will overrule the objection, at this time, anyway, and permit you to proceed.

BY MS. KORNFIELD:

Q Ms. Moe, were you instructed by any of the plaintiffs' attorneys to call the Illinois Department of Public Health?

A No.

Q Was it suggested that you call them?

A No.

Q You did this, then, on your own?

A Yes.

Q Do you recall the name of the person with whom you spoke?

A No, I do not. He did announce his name but I am afraid I don't remember it. I want to say Dan-something but I—but I really don't remember.

Q But you do recall that it was someone in the Ambulatory [583] Surgical Treatment Center Licensing—

A Yes.

MS. KREISEL: Objection. The witness did not say that. She stated that she called the general phone number of the department.

BY MS. KORNFIELD:

Q After you called the general number, what happened then?

A I asked to be put through to the Division of Licensing for ambulatory surgical center care.

Q And were you so put through?

A Yes, and a gentleman answered the telephone.

Q What did you ask him?

A I simply stated that I would like to provide termination services and was there any licensing requirement or requirements.

Q What did he say?

A He said "No."

Q Did he say anything else?

A But he said that he strongly recommended that I get an ASTC license.

I asked "Why?" and he said, "For the provision of the patient's well-being, to provide competency of care for the woman."

Q Until this telephone call Monday, had you heard from anyone at the Illinois Department of Public Health that they [584] were no longer enforcing the Ambulatory Treatment Center Act?

A No.

Q If I may just finish the question.

A I am sorry.

Q As against health care providers who wished to perform abortions along with other office procedures?
A No.
Q Mr. Bilstein, then, didn't tell you that when he spoke to you in 1982?
A No.

MS. KREISEL: Objection. The witness said 1981 or 1982.

MS. KORNFIELD: The record will reflect what her answer was.

MS. KREISEL: As to her conversation with Mr. Bilstein.

I think that the question is misleading.

THE COURT: Well, I am going to overrule the objection. I recall what the conversation was and it was a period between '74 and '82, and, as I recall, she thought that she called him in November of '82. She wasn't positive.

* * * * *

Cross-Examination

* * * * *

[587] * * * BY MR. FLAHAVEN:
Q I only want to know the counties that you mentioned on direct examination.
A Okay. On direct examination I believe I mentioned Cook County and Kane County, which is what I think I was asked.

THE COURT: And maybe DuPage?

MS. KORNFIELD: Your Honor, I think I said the names of the counties in my question.

MR. FLAHAVEN: I'm cross-examining the wrong person.

THE COURT: Yes, I guess so.

I wrote down "Cook County, Kane County and DuPage County."

MS. KORNFIELD: Those are the three that I had in my notes.

THE COURT: Yes.

BY MR. FLAHAVEN:
Q Now, is your knowledge as to those doctors' willingness to perform abortions in their offices based on conversations with those doctors?
A Yes.
[588] Q Is it based on anything else besides your conversations with those doctors?
A A couple of them whom I have known have performed them in their offices.
Q And you have seen them do it?
A I have assisted.
Q Okay. How many doctors have you actually seen?
A I've seen–

MS. KORNFIELD: I object to the question.

BY MR. FLAHAVEN:
Q How many doctors–you said that you were "assisting"?
A Yes.
Q And how many doctors have you assisted?
A How many have I personally assisted?
Q Yes. Who are willing–

MS. KORNFIELD: Objection again.

THE COURT: Just a second.

MS. KORNFIELD: It is not clear to me if he means in Cook, DuPage or Kane, or ever–

THE COURT: Altogether, I assume.

BY MR. FLAHAVEN:
Q I am talking about Cook, DuPage and Kane.
A I have personally assisted two physicians.

* * * * *

TRIAL TESTIMONY OF MICHAEL V. ACCETTURA

[639][1] * * * *Direct Examination*

BY MS. KREISEL:

Q Would you state your name and spell it for the record, please.

A Michael Accettura—A-c-c-e-t-t-u-r-a.

Q Where are you employed, Mr. Accettura?

A The Illinois Department of Registration and Education.

Q And in what capacity?

A Legal counsel.

Q Out of what office are you based?

A Springfield.

Q How long have you been with the department?

A 14 months.

Q Are you familiar with Section 4433, Subparagraph (1), of the Medical Practice Act?

A Yes, I am.

Q Are you aware of whether the department has a position as to the enforcement of that section of the act?

A Yes, I am.

Q And what is that position?

[640] A That if any complaint were received by the department pursuant to that section of the Medical Practice Act, it would be examined by the General Counsel's office for a determination of whether there would be any enforcement action taken pursuant to that section.

Q And why is that?

[1] Numbers in brackets refer to the Court Reporter's original pagination of the Transcript of Proceedings.

A Based upon the Marcowitz decision, in particular, and various following abortion decisions, it is obviously an area of controversy and the department's legal staff would review any complaint that did come in under that section because it does concern abortion.

Q Does the department have prosecutorial discretion in the initiation of disciplinary actions under the Medical Practice Act?

A Yes, we have absolute discretion.

Q Does the department have the authority to promulgate a regulation which would reflect the position which you have just described?

A No.

Q Why not?

A Any rule or regulation that we would promulgate must be based upon statutory authority. If a statute is in question or there is some doubt as to whether a statute is valid, we would have no authority to promulgate any rule reflecting that fact.

[641] Q So, Mr. Accettura, is the department going to enforce Section 4431 of the Act?

MR. GILBERT: Objection. No foundation. There is no foundation laid for this gentleman being able to tell what the department is going to enforce. Or what they are going to enforce or not enforce.

THE COURT: Well, I do think that there has been a sufficient foundation laid as to his position in the department, and he has testified that the General Counsel's office determines whether there is to be any enforcement action by the department.

What legal effect their position might be if it is not in the form of a regulation or a statutory amendment is something else and what effect it might have on the issuance of a preliminary injunction might be something else

but I think that it is sufficiently relevant to know what the department's position is.

I will overrule the objection and permit the answer to be given.

You might repeat the question again so he has got it in mind.

BY MS. KREISEL:

Q Do you recall the question?

A Yes.

Q And what is the answer to the question?

[642] A To the best of my knowledge, we would not.

* * * * *

Cross-Examination

* * * * *

BY MR. GILBERT:

Q Now, Mr. Accettura, on the face of the Medical Practice Act, if a physician were to perform an abortion outside of an ASTC or a hospital, that physician could lose his or her license, isn't that correct?

A As it is written, yes.

Q As it is written?

A Yes.

Q And I believe that it is your testimony that there are no regulations that say anything different?

A No.

[643] Q Have there been any notices sent to any physicians that say anything different?

A No.

Q Is there any reason that any physician in the State of Illinois would know that you are not enforcing that act? I mean, other than going to a lawyer who might look at the law?

A They would ask us.

Q They would ask you?

A Correct.

Q They could call you on the telephone and ask you?

A Yes. Happens all the time.

Q It happens all the time?

A Yes.

Q Do physicians call you on the telephone and ask you whether you are enforcing the provisions of the act about other things?

A What other things?

Q For instance, do you ever get calls, any calls, to see whether it is okay to engage in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public, which is Subpart (5) of 4433?

A I've never received any personally.

Q You don't get any calls before somebody is going to do something like that?

[644] A I have never received one, no.

Q No. All right.

Gross or repeated malpractice; do physicians call you to see whether you are still enforcing that one?

A I never received such a call.

Q Is there anything in the reg's that says that a physician should call you to see whether there are any particular provisions of the act that aren't being enforced at any particular time?

A Not that I am aware of.

Q Have you ever sent anything out to physicians saying that they should call you to determine which portions of the act are being enforced?

A Not that I am aware of.

Q Now, you do send things out to physicians all the time, don't you?

Isn't there a provision—I think that it is Section 14 of the act, 4429, that says that you send a renewal notice

and application, your department, to each physician, and it is each year that it is renewed, right, the license?
A I think that it is every two years.
Q Or every two years?
A Right.
Q Okay. And you also have a list that you publish every year under Section 15(a) of the act, which is Section 4432 of, [645] I believe, Chapter 111, that says that the department has to publish a list of the names and addresses of all physicians every year, isn't that right?
A Yes, we have a list.
Q And there is a computer, I assume—
A Right.
Q —that has a list of all of the names and addresses of all of the physicians?
A Right.
Q And I take it that it is a computer that in fact can mail things to all of the physicians, such as their applications every two years, and all?

You don't have somebody who is sitting there writing out the names and addresses of every physician, is that right?
A The computer doesn't mail them, we have to hand-mail them.
Q No, no, I am sorry. They are mailed but the computer prints out the addresses on an envelope for mailing, is that how it works?
A Well, I honestly don't know.
Q You don't know?
A I don't know; I don't know how they do it physician-wise.
Q But it is computerized, how you send out your applications at all?
A Right.

* * * * *

[648] * * * Q All right. Let's go back to the physicians in the Medical Practice Act.

Are you telling me that if—when your department decides that you are not going to enforce a particular section of the act here, no matter what section, whether it is the Ambulatory Surgical Treatment Center portion of it or any other portion of this act that affects the livelihood of a physician and the license of a physician, are you telling me that you don't inform physicians that you are no longer enforcing a particular section and you never send out any notices whatsoever to any physician?
A Not that I am aware of.
Q So you could, in effect, change—the entire act could be changed and it could be the policy of your department that you are not enforcing the act at all or you are not enforcing very important provisions that could affect the livelihood of the physicians of the State of Illinois and you never tell them?

* * * * *

BY THE WITNESS:
A We don't inform anyone of nonenforcement provisions of the act.
[649] BY MR. GILBERT:
Q On any matter?
A Not that I am aware of.

I am never aware of it having been done.
Q What if you changed the fee for registration, would you inform physicians then?
A They would receive that notification in their renewal. They are required to submit a fee with the renewal; that would be indicated there.
Q Okay. Do you ever publish any kind of interpretive regulations anywhere about what provisions of the act you are enforcing or not or what your enforcement policy is?
A No.

Q So, there is no way for any physician to know that they could be doing something in addition to what they are presently doing that may be prohibited by the act right now?

If in their professional judgment a physician thought that he wanted to do something that he couldn't do under this act and you were no longer enforcing that prohibition, there is no way for that physician to know that other than to call you, is that what you are saying?

A That would be the only way, I assume, that they would discover that fact.

Q So, are we just supposed to ignore the act itself and just call you any time we want—

[650] MS. KREISEL: Objection, your Honor. That's argumentative.

BY MR. GILBERT:

Q —and if I am representing a physician, am I supposed to just call you any time that I want to know—

MS. KREISEL: Objection. This is getting extremely argumentative.

THE COURT: Yes. Right. I will sustain the objection. I think that it is verging on argumentative now.

MR. GILBERT: Okay.

BY MR. GILBERT:

Q Does your department, I believe, and correct me if I am wrong, it often drafts legislation for the legislature regarding the Medical Practice Act, isn't that right?

A We do it, yes.

Q You do?

A Yes.

Q Changes that your department feels are necessary in the act with regard to the administration and enforcement of the act, isn't that correct?

A We introduce, yes.

Q Has the department ever introduced any kind of a bill regarding Section 4433, Subpart (1)?

A Not that I am aware of.

Q Is the department—and you may have answered this [651] already but I just want to make sure that we get this on the record, but the department hasn't submitted any kind of a rule or drafted any rule regarding its enforcement of Section 4433, Subpart (1), has it?

A No.

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DEFENDANTS' EXHIBIT NO. 7

DEPOSITION OF JOHN J. BARTON, M.D.

Direct Examination by Mr. Gilbert

[62][1] * * * Q. Do you think it's probably around a thousand dollars or more now?

A. I would just be guessing, but I wouldn't be surprised if that's involved, yes.

* * * * *

[76] * * * Q. What type of a physical facility is used for the first trimesters?

A. What I just described. They're done in the main operating room.

Q. The first tri's as well as well as the seconds?

A. Yes.

* * * * *

[77] * * * Q. You mentioned there are others either in your practice or residents at Illinois Masonic who do perform perhaps more first trimesters than you?

A. Right.

Q. Where are most of those performed?

A. They would be done through same day surgery in the main operating room as well.

Q. Main operating room. Are there different size operating rooms at the hospital?

A. Yes, there are.

Q. Do you think the size of the operating room is an important element in the safety of the abortion procedure?

A. Well, again, I am not a structural engineer. The only thing I would ask for is that there be sufficient area

[1] Numbers in brackets refer to the Court Reporter's original pagination of the Transcript of Proceedings.

for the supporting equipment that's needed for an operation or for any complication that might result from that operation. I don't believe it's fair to compare the main operating suite of Illinois Masonic with another standard. Our rooms are big, probably bigger than we need, but they were developed that way for several reasons, one of them [78] being the fact that we have more people in the room. We have medical students and residents, both on the anesthesia side and on the gynecological side in terms of residents, student nurses.

I have operated literally in the sub-basements of parking garages in West Beirut and we didn't need the size that we had there, but we were performing a different function.

Q. Do you think when you operated in the sub-basement of a parking garage in West Beirut that you had what you needed from a medical standpoint in terms of room?

A. Not really. That was by necessity because the hospitals were destroyed. It was during the bombardment during the siege in '82.

I was trying to stress the point that I think we have more than an optimal situation at Illinois Masonic and the operating room and the operating suite was designed because we have probably different programs that would impact on a general community hospital.

* * * * *

[95] Q. What type of—

A. Indeed—I can't recall. I'm trying to think if I even performed one, but I don't believe I did. But I have certainly seen them performed.

Q. Have you ever performed a first or early second trimester abortion outside of Illinois Masonic?

A. With the possible exception of having—which I'm trying to bring to mind—it was in Fort Defiance, Arizona. That's another indian hospital. I may have. We had a very busy surgical schedule that winter. I may have.

But we had National Health Service Corps doctors who would do those procedures and when a consultant volunteer would come they would just cover them. We really didn't have to do the minor procedures ourselves.

Q. And you would consider the first and early second trimesters to be a minor procedure?

A. First trimesters.

Q. Minor in the sense of limited risk or what do you mean by "minor"? I don't want to put words in your mouth.

A. It's a traditional classification between major and minor gynecological surgery is what I'm [96] using, and I place it in the category of a dilatation and curettage diagnostic, which we would classify as minor.

Q. And a dilatation and curettage diagnostic is performed for what purpose?

A. Oh, as an example, to rule out cancer of the endometrium.

Q. Is that a relatively widely performed procedure?

A. Yes, it is.

Q. What occurs in a dilatation and curettage diagnostic?

A. The procedure is essentially the same as that of a first trimester abortion except that the condition of the uterus is different and with the exception that it may be fractional, and we use a sharp curettage, specimens taken from different portions of the uterus and cervix.

Q. That's what you mean by "fractional"?

A. Yes.

Q. As opposed to taking specimens from the entire—well, it wouldn't be specimens, but in the abortion there would be a curettage of the entire—

A. Endometrial cavity, yes.

[97] Q. That is the cavity of the uterus or is that something else?

A. Of the uterus.

Q. Essentially the same as the first trimester abortion?

A. But not the same, because I qualified that, if you recall, on the condition of the uterus.

Q. What difference does that make?

A. Well, there are several differences that can occur in the evacuation of a pregnant uterus as opposed to obtaining a tissue specimen from a nonpregnant uterus and those basically are the size of the uterus in relation to the—pregnancy changes the hormonal influence that makes the uterus softer, more easy to perforate, but essentially, the step by step procedure is about the same operatively.

Q. Is there a substantially greater risk of complication in the first trimester abortion as opposed to in the dilatation and curettage diagnostic?

A. Yes, there is a higher rate of complication in the first trimester abortion.

Q. Is it substantially higher?

A. I think it probably is statistically significantly higher.

[98] Q. Do you have any statistics to back that up?

A. Not right at hand.

Q. Have you ever seen any statistics that suggest that?

A. Yes, I have.

Q. Do you recall where you saw that?

A. Not specifically, no.

Q. Are you certain that there are statistics comparing the procedure?

A. Yes, the major complication, that of perforation, is higher in the first trimester, under twelve week abortion than a straight plain diagnostic curettage.

Q. Can you tell me how much higher? Do you have any sense?

A. No, but I would say it's statistically significant judged by a P value.

Q. What do you mean by a P value?

A. That's a statistical analysis of probability and whether it's significant or not.

Q. Do you think—is the risk of perforation substantial in the first trimester abortion?

[99] A. I don't know what "substantial" means. I really don't.

Q. Would you consider that a major risk?

A. It's one of the leading complications. In terms of incidence, probably in a qualified operator's hands should be less than 1 percent.

Q. Would you consider that to be a low incidence?

A. Anything less than 1 percent probably would be classified as a low incidence, yes.

Q. And you mentioned, I believe, that that is the highest—that's the most likely complication of a first trimester?

A. Most serious.

Q. What other serious complications are there in the first trimester?

A. Hemorrhage, infection, are the leading.

Q. Basically the same ones you were discussing before as occur in a D&E in early second trimesters?

A. Yes.

* * * * *

[100] * * * Q. What factors are the most significant in determining the safety of a first trimester abortion?

Do you understand the question? I'll be happy to Friday to rephrase that.

A. Are you really asking what leads to the majority of the complications?

[101] Q. Well, I'm really asking what—why don't you answer that question. That's a good question. I'm not sure that's the same one, but why don't you answer that one anyway.

What leads to the majority of complications in a first trimester abortion?

A. First, there are probably an irreducible minimum of complications that are going to ensue no matter how skilled the operator, but certainly, the most important factor in the performance or in the entire scenario of a first trimester abortion is the competence of the individual performing it, not to imply that he is not going to be—he or she aren't going to have complications because there is that irreducible minimum.

I think that most closely answers your question.

Q. What's the next most important factor?

A. It probably would have to be the conditions under which it is performed.

Q. What do you mean by that?

A. The entire general milieu of the—as an example, I'm sure before abortions were legal there were some quite competent people performing them, but [102] the restrictions that they had in where they were performing them would lead to complications, whether it be the traditional back alley motel room or surreptitiously done in the doctor's office.

Q. Could you elaborate more upon what you mean there?

A. The first trimester abortion we—we are perhaps so comfortable with the procedure we become a little bit unaware that it still is an operation and deserves the respect of any operation.

What I'm referring to is the skill of the operator and what facilities he has to perform it, that the instruments are a certain standard, that the sterility techniques and

the availability of sterile instruments are adequate, and then certainly, the backup support for any complication that might ensue is appropriate.

Q. Anything else in the area of conditions?

A. Well, these are the three major things that would reduce rates of complication: skill of the operator, the environment in which he operates, and the availability of resources to handle any complications.

* * * * *

[126] * * * Q. What makes something an operation as opposed to not an operation?

A. I'm not sure I can answer that. I am giving you my qualified judgment.

Q. What about a first trimester abortion makes it an operation?

A. You are performing a surgical technique. You are entering into a body cavity where if you're going to get hung up on an IUD, as an example—it's interesting that some have tried to classify that completely as nonprocedural such as the chiropractors petitioning the Illinois Medical Practice Act that that is nonprocedural.

We have issue with that, that it is procedural. It is indeed invasive, but probably on the standard of, say, doing a phlebotomy, of taking blood. It's invasive in that manner, but not holding the merits of an operation.

Q. Are you experienced or knowledgeable about the insertion of IUD's?

A. Yes.

Q. Are there complications that arise from that process?

[127] A. Yes, there are.

Q. And what are those?

A. Perforation, hemorrhage, and infection. And then perhaps the worst complication, which is the inappropriate placement to where it doesn't succeed in performing why it was put in.

Q. Those are basically the same complications we were talking about before with regard to first trimester abortions, second trimester D&E's, and D&C's?

A. But not to the degree.

Q. Not to the degree in the IUD?

A. Yes. If I can clarify that—

Q. Certainly.

A. If you get a nosebleed, it's hemorrhage. If you sever a carotid artery it's hemorrhage, but not quite of the same degree.

Q. In the IUD the perforation and the hemorrhage would be occurring in the uterus as well?

A. It would be in the wall of the uterus, yes.

Q. What would be different about the perforation in the IUD circumstance from the perforation that might occur in a first trimester [128] abortion, for instance?

A. The uterus is smaller without the hormonal changes of pregnancy. The wall is firm and usually a perforation without any subsequent injury will heal itself without problems. In the first trimester abortion it's a highly vascular organ that you're dealing with with the uterus.

Q. What do you mean by "vascular"?

A. It has many vessels in terms of the blood supply, increased blood supply in the uterus itself. Consequently, a perforation of that organ as opposed to the nonpregnant one with the very small cannula of an intrauterine device would be much more dramatic.

Q. Have there been deaths from perforations due to the insertion of intrauterine devices, do you know?

A. I don't know if I have heard of any reported as a direct complication of the operative procedure. Delayed complications, yes.

Q. Do you think that IUD's should be inserted in an environment like the operating room you were talking about?

A. I believe I have already answered that by saying I don't consider insertion of an IUD an [129] operation. I do consider a first trimester abortion an operation.

Q. Again, I guess I'm not quite understanding you as to what makes one an operation and the other not. Is it the risks involved or is it the nature of the procedure?

A. Our nature of classification of the procedure.

Perhaps I can clarify it, maybe not for me as much as for you because I'm not sure where you draw that line. I do know on the International Classifications for Summarizing Charts, as an example, first trimester abortion is considered an operation. Intrauterine device is considered a procedure.

Q. Where does the D&C diagnostic fit in?

A. Operation.

Q. Who establishes these, this line that you just discussed?

A. I believe it was a joint effort through the Library of Congress and the AMA. I'm not quite sure.

* * * * *

[137] * * * Q. Do you think a protocol is necessary for a first trimester abortion, to have a protocol in the site of the procedure?

A. I think it behooves the individual to know, to have protocols developed for support, no matter what operation it is.

Q. Do you think those protocols are necessary for a procedure as well?

A. As opposed to an operation?

Q. Yes. Well, protocols, again, I don't want to stress that as if it were put in stone. Some will require them; some will not.

[138] A protocol might not even be something that's written and formally presented in the operating room.

Again, I have already mentioned to you that we don't have—I don't control by protocol the first trimester abortions that are done at our institution. What I do is to be sure I make available the things I have just listed for you.

Q. But you leave the protocols to the physician?

A. Sure.

* * * * *

[150] * * * Q. Do you know of any standards anywhere, whether they be laws or standards of some governing body in the medical profession that suggest or require that D&C's be performed in operating room settings?

A. That isn't a standard that I believe any body would set.

* * * * *

[157] * * * and I want to read to you Regulation 205.12(b)(9)(F), which says:

"Any corporation operating an ambulatory surgical treatment center devoted primarily to providing facilities for abortion must have a physician who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the center, on the Board of Directors as a condition to licensure of the center."

Are you aware that that provision is in the Ambulatory Surgical Treatment Center regs?

A. Yes.

Q. And I will represent to you that that—

A. Can I read it?

Q. You certainly may.

A. This is beginning—

Q. The (F) that's in front of you there on the regulations.

A. I would have to have an interpretation of that. I don't know what "corporation" means.

Q. All I can—the only thing I can tell you and represent, and I'm sure that Ms. Kreisel will not disagree, is that that provision, which is part of the general provisions of the Ambulatory Surgical [158] Treatment Center Regulations only—have a restriction that only applies to centers providing facilities for abortion or facility for abortions.

A. To be frank with you, I not only—this is new to me. I have been provided with these documents, but was not familiar with that section. I think that this would even be, would defeat any purpose, the way this is worded, for even a safety factor.

As an example, it does state "a physician who is licensed to practice medicine in all its branches actually engage in the practice of medicine at the center." That could be a psychiatrist who has never in his life performed an abortion or would, I feel, be qualified to perform an abortion.

I do not agree with that, no.

Q. So are you saying that that particular provision in fact could be medically harmful?

A. I just don't understand what it means. As I say, I don't know whether it could be harmful, but it certainly wouldn't even be productive, because all physicians in the State of Illinois are licensed as physicians and surgeons, but that does not necessarily mean that they are surgeons.

* * * * *

[160] * * * Q. Do you have an opinion about those sections, the fact that there are specific sections in there setting up specific regulatory provisions regarding the obstetrical and gynecological procedures performed as opposed to other procedures?

A. In direct answer to your question, Subpart (G) on Section 205.710, Abortions, I believe that that's general

enough that you would have to agree with it, which states:

"Abortions shall be provided the public at the same standards of safety, effectiveness, and regard for the patient's rights as any other health service."

Q. Do you have any concern that there are no similar sections for any other procedures that are [161] performed in an ambulatory surgical center?

A. Well, I would not know why they would put this in, frankly.

Q. Do you think that that's necessary?

A. I think it rather begs the obvious. I think that no matter if you erased the word "abortion" and put any operation that shall be provided would mean—it would mean the same to me.

Q. Do you think just the general licensing standards for physicians and the possibility of malpractice suits would be enough to cover that same area?

A. Oh, I can't be sure of that. As you know as an attorney, malpractice suits aren't always produced by a written document.

Q. I guess the question—well, go ahead.

A. As I have—as I think I prefaced my comments at the beginning of this deposition, anything that would be in this document that would stand as an impediment between a patient and her right to choose abortion, I would not agree with. If these are so interpreted by some, then I would have to say that I don't agree with that section of the document.

Q. Do you have any knowledge of how the [162] provisions of the Ambulatory Surgical Treatment Center Act are interpreted by the Department of Public Health?

A. I have been led to believe that they are not singling out abortion facilities for any kind of, oh, special consideration, if you will.

Q. Does that belief stem from that conversation that you testified to before with Dr. Turnock?

A. Yes.

Q. Is there any other source of that belief?

A. No, I have had no experience with, as I stated earlier, with the ambulatory surgical centers.

Q. If the Ambulatory Surgical Treatment Center Act and regulations and other provisions singled out abortion facilities for special treatment, would you consider that to be inappropriate from a medical point of view?

A. Well, not necessarily from a medical point of view, a philosophical point of view. I would find issue with it as to what the intent then was behind that regulation.

The only two standards that I have really—[163] and as I have expressed this to counsel and to Dr. Turnock—is that I can't agree with anything that stands between the right of a patient, any impediment that prevents them from having a safe and effective abortion.

On the other hand, I do believe that they probably should have some regulatory authority and the most appropriate probably is the State. These individual items that you're pointing out to me I believe may be interpreted as an impediment, but I was given to believe that these are not being enforced by the Illinois Department of Public Health.

* * * * *

[165] * * * Q. Do you think there is any reason, medical reason that there should in the case of obstetrical-gynecological procedures performed in an ambulatory surgical center as opposed to other types of medical procedures—and by "procedures" here I'm talking of operations as well—that there should in terms of the obstetrical-gynecological procedures be a particular requirement that there be a registered professional nurse with postgraduate education or experience in that field on-site

supervising and directing nursing personnel, when no such provision is in place with regard to any other type of medical procedure?

A. Without addressing first the latter part of your question, I will repeat what I said earlier, [166] that all operations deserve the same and equal dignity, and I agree with you that I wouldn't spell it out specifically for a gynecological operation as opposed to, say, a cosmetic operation. The quality of the people involved is the important issue, not the specification as that spells out.

I would not agree that has to be a standard.

* * * * *

[168] * * * Q. Do you think it's necessary for physicians to be regulated with regard to those matters as opposed to relying upon the skill and common sense and logic and integrity and honesty of the particular professional involved?

A. It begs the obvious. Counseling should be done. I believe—again, I'm going to revert back to my statement that all operations demand the same dignity and certainly, counseling and informed consent should be obtained in any situation prior to any operation.

Whether it's necessary to spell it out as these pages, these documents you have given me to review, I can't speak to that. I don't know what they mean really by "demonstration of such counseling qualifications." I'm afraid I don't even know what that means, whether there is a school or certificate they receive to be a qualified counselor.

It is indeed true that in the performance of our second trimesters at Illinois Masonic, all of this is provided for, but it was provided for before we followed or were aware of such a guideline. It is just good common sense.

Q. Let's go on to 205.740, if you would take a look at that.

A. Yes, preoperative requirements.

Q. Yes?

A. It's my personal belief that anything over twelve weeks should be done in a hospital environment, yes.

Q. Do you think it's medically necessary that that occur?

A. That's my professional feeling, yes. I understand that this has been overruled by court action, however.

Q. How do you know that?

A. This was held unconstitutional.

Q. It was held unconstitutional, to your knowledge?

A. This is my understanding.

Q. How did you come by that understanding?

[170] A. Newspapers.

Q. Let's turn to Section 205.750, Postoperative Requirements.

A. I could agree with that, but again, it's—the one certainly is, Subsection (a) with RH Factor sensitization is consistent with good medical practice. Availability of family planning services certainly is compatible with good medical practice. I don't know whether it's absolutely mandatory.

Q. When you say that the consideration of the RH Factor is compatible with good medical practice, do you mean to say that any competent physician would know that and do that as a matter of normal procedure?

A. Sure. It goes right back to what we discussed on reduction of complications. First is the operator. And in the second, the reason I have a little trouble with that, in the hypothetical of a genetically diseased baby where an individual decides to terminate the pregnancy, why do they need counseling on family planning? They probably need genetic counseling and they certainly might wish to have a child again as soon as possible or have a pregnancy result.

[171] To make it mandatory to them might be the worst thing you could do, if you understand what I'm saying. You're telling people not to get pregnant who want to get pregnant, whose desire is to have a family.

Genetic counseling, yes, but not mandatory contraceptive counseling.

* * * * *

[186] * * * Q. "This facility" is referring to an ambulatory surgical treatment center, I can tell you that. Is there any medical reason for—

A. No.

Q. —an ambulatory surgical treatment center that otherwise meets what you would consider to be appropriate medical standards to be identifiably separate from other facilities and functions?

A. No. Actually it's a matter of semantics. I think most hospitals' so-called same day surgery programs are, if you will, ambulatory surgical centers.

Q. I understand, but is there any reason that, let's say, a same day surgery center, if you say they are ambulatory surgical centers, needs to be identifiably separate from other—they couldn't just [187] be a center in another building?

A. I don't see how that could affect the standard of care. I really don't even know what that means.

* * * * *

PLAINTIFFS' EXHIBIT NO. 26
DEFENDANTS' EXHIBIT NO. 9

DEPOSITION OF JAMES A. LINDER

Direct Examination by Ms. Chaiten and Ms. Connell

[40][1] * * * Q. Have you studied those complications in any way in order to determine how that effects the facility's size?

A. Basically we are talking about a surgical procedure. We are talking about cutting or scrapping or pulling off with suction, human flesh. Human flesh does not part anywhere in the body easily, and there is hemorrhaging in any procedure.

Q. Do you consider yourself to be qualified to testify about those complications in an abortion procedure?

A. I don't understand what you mean.

Q. You told me before that you consider yourself an expert in the area of architecture and facility design, and now you are telling me about complications in an abortion procedure. I want to know what basis you have for that?

A. Discussions with medical people. Discussions with providers. A D & C, for instance, a doctor, I have dealt with them, have said that they can make a slip with a currette, and they can [41] actually perforate and cut through the lining.

Q. So in other words, the skill of the physicians involved in the procedure is very important to the safety of the procedure?

A. I think that is true about any procedure.

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[1] Numbers in brackets refer to the Court Reporter's original pagination of the Transcript of Proceedings.

Q. If there were a perforation of the uterus in the performance of a first trimester abortion, what kind of equipment and people would be needed?

A. X-ray equipment?

Q. Yes.

A. Yes, I think probably it is more a realization of the situation. Packs are commonly available. It is a medical question you are asking me.

I think probably in the case of perforation, a requirement that they be located within 15 minutes of a hospital was intended, to require a place for this sort of complication, within 15 minutes of a hospital, if he has got a problem and made a boo-boo.

Q. How does that effect the procedure room size?

A. In either case, I would, with the limited space that might be available for a suction machine, I would not want my daughter or my wife involved in a procedure of the emergency nature with hemorrhaging [42] in a very, very small room. I would hope that there would be other equipment available. If there were general anesthesia, I would hope there would be an anesthesiologist. I would hope that other equipment besides a simple suction machine would be available.

Q. What other equipment?

A. Well, you are asking me medical questions.

Q. But you have said to me these are factors you take into account in determining whether or not a facility is within substantial compliance with the regulation.

I am assuming if you are taking these factors into account that you know what they are.

A. You represent the provider, you indicate to me in your written program what pieces of equipment you are going to need, and it is given to me, and I don't have to be a doctor. I can be an architect. I am really not qualified to answer your medical questions.

Q. So, in other words, you rely on the medical judgment of the provider in determining what is necessary for the procedure?

A. Always.

* * * * *

[67] * * * BY MS. CHAITEN:

Q. So—

A. So the 250 square feet, with a minimum dimension of 14 feet, was determined by a typical procedure involving general anesthesia, an operating table, an anesthetist, a nurse, a surgeon, and space.

Now, a table is about six feet long, and an anesthetist is going to take about three feet. That's nine. Nine from 14 is five. We've got 30 inches at one end of this procedure table and 30 inches at the other, which is bear minimum.

If—and I'm not sure what 14 into 250 is, but I think it's less than —14 would be 256. So the area of the room was to accommodate that kind of a procedure in each facility.

Q. So in other words, you applied what you explained to me before about worst case tempered by reasonableness,—

A. Yes.

Q. —that you've looked at all of the types of procedures that might be performed within an ambulatory surgical treatment center, and made a [68] determination based on that as to what the largest requirement would be so that you could make sure that that particular procedure would be covered?

A. Yes, and I also have to relate it to the hospital standard, which also is a surgery room of 360 square feet and a minimum dimension of 18 feet.

Q. Mr. Linder, does the hospital's requirement for the size of the procedure room that you're mentioning apply to minor surgery that's performed in a hospital?

A. We do have—I'm not sure whether we have them now. We have had standards that deal for—with endoscopic procedures and so on. These are not surgery cases. These are basically noninvasive, in the sense that the skin isn't penetrated.

Q. So in other words, an endoscopic procedure performed in a hospital would have a less severe requirement than a regular hospital surgery room?

A. Yes.

Q. Okay. What is that requirement?

A. 250 square feet.

Q. So it's the same as the ambulatory surgical treatment center requirement, is that correct?

A. Yes.

[69] Q. Okay.

A. One, of course, being surgery and the other being an observation. See—

Q. I'm sorry. What do you mean "observation"?

A. An endoscopic procedure does not involve surgery. It's a noninvasive procedure, in the sense that your skin is not penetrated.

There is no blood, there is no—

* * * * *

[77] A. How did we come up with it?

Q. Yes.

A. I think we echoed what is almost universally available.

Q. For what type of facility?

A. Any type of facility. Probably your home.

Q. Every facility has to have an eight-foot ceiling?

A. That's what it says.

Q. That's not what I mean. I mean building codes require eight-foot ceilings, is that—

A. You know, this (indicating) is 10. It's a big building. But this is minimum. Yes, it is universally accepted.

Q. Universally required by building codes?

A. I would—

Q. I'm not asking you to promise me that every building code in the world requires an eight-foot ceiling.

But what I'm asking is, is this sort of thing covered, then, by building codes?

A. It may be. It may be.

* * * * *

[79] * * * Q. Okay. Why don't we turn down to 1620(b). Okay. This is with regard to plumbing fixtures. I'm interested in the requirement that water supply spouts have—be five inches from the rim of the fixture.

Where did you come up with this requirement?

A. This is a standard, almost universally accepted requirement. The function is to allow a nurse to fill a pitcher. It's called a gooseneck spout. It's very difficult to fill a pitcher unless [80] you have a gooseneck spout.

Q. And they're all five inches?

A. Generally.

Q. Would there be a problem if it was four-and-a-half inches?

A. Not if they had a small pitcher.

Q. So in other words, would that be substantial compliance?

A. I think so. I think that's just an awful lot of detail to say someone is in noncompliance. You know, the proof of the pudding is can you fill a pitcher?

Q. Okay. So the regulations require that it be five inches when, in fact, it's applied to mean "can you fill a pitcher?"

A. That was the intent in writing the regulation.

Q. How was it enforced?

A. With good judgment.

Q. Do you know of facilities that have been cited for deficiencies?

A. No.

Q. Do nurses in all ASTCs need to fill pitchers?

[81] A. That seems to me to be a medical question.

Q. Now, are you saying that you don't feel competent to answer that question because it's a medical question?

THE WITNESS: Should I?

MS. STEVENS: Well, if you know—

BY THE WITNESS:

A. No, I think I know. I don't know of any ambulatory surgical treatment centers where, at some point or another, medications aren't dispensed and taken at the site. Okay.

So if you're going to take a pill, you need water. And that's what this is for, so you can get a chance to get some water in the pitcher.

BY MS. CHAITEN:

Q. Do all nurses have to fill pitchers in order to give patients water for medication?

A. I'm sorry, would you say that again.

Q. Is it necessary for a nurse to fill a pitcher in order to give a patient water in order to take medication?

A. If what you mean is there's no other way? Is there no other way?

Q. Yes.

[82] A. I am sure there are other ways.

* * * * *

[88] * * * Q. Is a hospital a health care facility?

A. Yes.

Q. Can you obtain a staph infection in a hospital?

A. I believe you can.
Q. Is a staph infection a nosocomial infection?
A. Yes.
Q. Can you obtain a staph infection outside of a hospital?
A. I think so.
Q. Okay. What kind of sepsis is airborne?
A. Any sepsis that can move in the air.
Q. Can you give me a specific example?
A. You mean a medical identification of a particular sepsis?
Q. Yes.
A. You're out of my field.
Q. Okay. Why don't we go now to 1540(h), I believe.
A. Are we going back?
Q. Yes, we're going backwards.
A. Okay.
Q. This deals with filter efficiencies. Can [89] you explain this chart to us.
A. Well, it is essentially a chart establishing, in two broad areas, the number of filters in an air-handling system, and the efficiency of the filters.
Q. Okay. Why is it that these requirements are necessary for an ambulatory surgical treatment center?
A. An ambulatory surgical treatment center, by definition, is going to include surgical procedures. We've learned that airborne transmission of sepsis is possible and that filtration of the air helps reduce the airborne transmission of sepsis.
Q. If the procedure is not a surgical procedure, in the sense that it is not a procedure that includes an incision of any sort or a tearing of the flesh, as you put it before, is it necessary to guard against this sort of airborne sepsis by use of these filters?

A. If there is no surgery?
Q. No surgery.
A. This, then, is hypothetical because we're dealing in a framework of something that does involve surgery.
[90] Q. If we're talking about a procedure that does not include an incision,—
A. Okay.
Q. —is it necessary to use these filters to guard against airborne sepsis?
A. It's somewhat of a medical question you're asking. However, from my standpoint, if the doctor felt that the patient's condition, other than surgery, was such that the patient should be protected with, say, more than normal filtration, it would be indicated.
Q. If there was a facility in which no surgery was performed—by that, I mean, there was no procedure performed in which an incision was made—would the IDPH cite that facility for a deficiency for not meeting these requirements?
A. You'd have to be a little more specific, the type of facility that you have in mind, and the type of procedure that you have in mind.

* * * * *

[91] * * * Q. Okay. Let's say that a physician is dealing with a miscarriage situation, which is the completion of a spontaneous abortion. In that situation, it's a D & C just like a gynecologist performs in his or her office.
In that situation, is there a need for special filters to guard against airborne sepsis?
A. You're dealing, then, with an open wound?
Q. No, no. There is no wound. It's a miscarriage situation.
A. Well, my impression is that miscarriage is a wound.

* * * * *

Q. So in other words, when you were involved in promulgating these regulations, you did so based on the assumption that the procedures performed in these facilities would be a—of a surgical nature, that there would be open wounds that you were dealing with and, therefore, you were protecting against this sort of infection?

A. By definition, that's what these are.

[92] * * * BY MS. CHAITEN:

Q. Mr. Linder, did you personally consider a facility that did not involve incisions or open wounds?

A. I'm not aware of any.

Q. Okay. And so in instructing your staff on how to inspect these facilities and how to enforce these regulations, you did not take into account the possibility that there would be a facility in which there are procedures being performed that do not involve incisions?

A. As I've indicated to you several times before, we try to use judgment in enforcement of our standards.

* * * * *

[93] * * * Q. You say you use judgment. I'm asking is there any guideline—written guideline that you or your staff members follow when inspecting a facility that only deals with procedures that don't involve incisions?

A. No, we don't have guidelines at all.

Q. Okay. Does the IDPH regulate air filters in physicians' offices?

A. Physicians' offices are not included in the list of licensed facilities.

Q. So in other words, the IDPH doesn't regulate physicians' offices at all?

A. No.

* * * * *

[124] * * * Q. Well, that is in a side.

Mr. Linder, have any of the individuals that you've just named, or their successors or their predecessors, Mr. Cuddleson, Mr. Barth, the physician who's the assistant director, or Dr. Turnock, ever given you any written standards for interpreting this substantial compliance for the inspection of the mechanical and the physical plant aspect of the ambulatory surgical treatment center regs?

A. No, we have statements concerning conduct, we have all kinds of policy sort of things. But the detail, no.

* * * * *

DEFENDANTS' EXHIBIT NO. 8

DEPOSITION OF MARY JANE RAMSAY, R.N.

Direct Examination by Mr. Gilbert

* * * * *

[26][1] Q. How often do you do a licensing survey of an ASTC?

A. We visit the ASTCs quarterly.

Q. And that is quarterly visits for a licensing survey?

A. Yes.

Q. How often do you visit the acute psychiatric hospitals?

A. Annually.

Q. And the end stage renal disease units?

A. Every 18 months.

Q. For Medicare reviews of ASTCs, how often are those?

A. Annually.

Q. Is that pursuant to Medicare regulations?

A. Correct.

Q. And Medicare reviews of hospitals, how often are those conducted?

A. Those hospitals that are Joint Commission accredited, we don't do a Medicare survey—except for 10 percent again annually—the federal government mandates that 10 percent of the hospitals, what they call a validation survey, so that we go in within sixty days of Joint Commission and do a full * * *

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[1] Numbers in brackets refer to the Court Reporter's original pagination of the Transcript of Proceedings.

[41] * * * Q. Do you have any personal opinion apart from the regulations about how Doctor Ragsdale and his clinic operate?

A. Can I give a personal opinion?

MS. KREISEL: I will object on relevance, but go ahead.

BY THE WITNESS:

A. I feel that he has very compassionate people who really have the interest of the patients at heart. This is a personal opinion.

BY MR. GILBERT:

Q. I understand. That is what I am asking for. Do you feel that he as well is a compassionate person with the interests of the patients at heart?

* * * * *

[74] * * * Q. Is there some current gestation period that you are enforcing that reg with regard to? In other words, is there some outer limit now?

A. It would be the second trimester. Well, the—there was not a specific number of weeks given to us. In just—we are not enforcing this reg.

Q. You are not enforcing it at all; is that—

A. We are not enforcing the 12 weeks, correct.

* * * * *

Q. Do you know whether there has ever been any public notification that this section, this 12 week requirement, is not being enforced?

A. I have no way of knowing whether there was public notification.

Q. Have you informed the operators of the various ASTCs that you survey in which abortions are performed that this section is not being enforced?

[75] A. If they ask me.

Q. You have—you have not told them?

A. I have not specifically gone in and said, Okay. Guess you can do second trimester—"

Q. Not all of the facilities—ASTC facilities that you survey perform second trimester abortions, do they?

A. No, I don't think so.

Q. Most don't; isn't that—

A. That's correct. I don't believe that most do.

Q. Do you know any that do?

A. Yes.

Q. Which ones are those, if you can recall?

A. Well, I think that Northern Illinois Medical Center does some second trimester, and I think that—I think Hedd SurgiCenter does some.

* * * * *

[99] MR. GILBERT: It has never—

MS. KREISEL: The Legislature has not deleted that language from the Act.

BY MR. GILBERT:

Q. Let me just ask you, do you still enforce—do you enforce the ASTC Act with regard to facilities utilized to terminate a pregnancy, even though they are not devoted primarily to that purpose?

A. I only go to a licensed facility, so—

Q. You don't know whether that provision is enforced now or not.

Have you ever been told not to enforce that provision about—concerning facilities where pregnancy terminations occur, even though they are not devoted primarily to that purpose?

A. No, I have never been told either way, but the facilities I go to are licensed and none of them currently have asked not to be licensed that I am aware of.

MR. GILBERT: Okay. I want to make it clear, Kathleen, you are saying the Department no longer enforces that provision.

MS. KREISEL: That's correct. I think I said it a million times.

[100] MR. GILBERT: There's been some question in some of the things that we have seen and there is nothing in writing that says that, though; is that correct?

MS. KREISEL: I think that you received some memos that discuss that very issue and there is the Markowitz case.

MR. GILBERT: There is no regulations or rules that—are you aware of any rule or regulation that says that rule doesn't apply?

MS. KREISEL: There isn't one.

BY THE WITNESS:

A. No.

* * * * *

BY MR. GILBERT:

Q. Are you aware of any public notice being given that that provision doesn't apply?

A. No, I am not aware of any public notice being given.

* * * * *

[108] * * * Q. Let's go to 205.750, which is post-operative requirements in Ob-Gyn services.

Are you aware of any ASTCs that do not comply with the letter of 205.750 yet have been found to be in substantial compliance?

A. No, I am not aware of any.

Q. How about 205.760?

A. 205.760 is not being enforced.

Q. It is not being enforced?

A. No.

Q. Is there any written indication anywhere that it is not being enforced?

A. Not that I am aware of.

Q. Have you informed the facility operators [109] that you deal with that it is not being enforced?

A. After the fact, yes.

Q. What do you mean by after the fact?

A. After it was not being enforced for a while, then I tried to tell people. I won't say I've told every single facility.

Q. When you told these people in these facilities, have they indicated to you that you have been the first one to tell them?

A. Some of them, but not necessarily all of them.

Q. There is no indication, to your knowledge, that Springfield sent out any kind of a notice to the operators?

A. No, there is no notice.

Q. You don't know that?

A. I don't know that.

Q. You are not prepared to talk about plumbing requirements, electrical grounding rules?

A. No.

* * * * *

[111] * * * Q. Do you have an opinion as to whether the ASTC Act and its regulations are effective in assuring quality care in facilities where abortion procedures are performed?

A. Would you state that again?

MR. GILBERT: Would you read it again, please.

(The record was thereupon read.)

BY THE WITNESS:

[112] A. These are the minimum requirements for facilities, so if facilities meet these regulations, they would at least be minimally—

BY MR. GILBERT:

Q. Well, I don't believe that really answers the question.

Do you have an opinion as to whether or not the regulations assure the quality of services as opposed to whether they provide minimum requirements?

A. No, I don't believe that they one could say that they absolutely assure quality.

Q. Do you think they affect the quality of services performed?

A. I would think that they affect the quality that the patient's receive minimally.

Q. If a facility were to meet all the ASTC Act regulations—the Act and the regulations—I am talking about facilities that perform abortions—is that enough for someone to be confident that they will get quality service in that facility?

A. The regulations don't—

THE WITNESS: Can I ask her a question?

MS. KREISEL: Yes.

MR. GILBERT: I'd prefer that you—

[113] MS. KREISEL: I am going to object.

MR. GILBERT: —wait, that you not ask the question while the question is pending. That I object to. You can talk to her after you answer the question.

MS. KREISEL: I am going to object to this line of questioning because I don't think we have established that this witness is a medical expert and what expertise she would have to answer that question.

BY MR. GILBERT:

Q. Please answer the question.

MS. KREISEL: If you can answer the question. If you can't, don't.

BY THE WITNESS:

A. I don't believe that the regulations cover the discretion of the—and the integrity, necessarily, of the providers of care.

BY MR. GILBERT:

Q. Do you consider the discretion and integrity of the providers of care an important element in the quality of care that is given?

A. I think it is important in all phases of our life, yes, no matter what we are, where we are or [114] what we are dealing with.

Q. When you talk about the discretion and integrity of the providers of the care, do you include with that the medical expertise and abilities of the providers?

A. Yes.

Q. And in those things, the discretion, the integrity, the medical expertise, abilities of the providers are not governed by these rules and regulations that you enforce?

A. Not totally.

Q. To what extent are they governed by them?

A. Just the minimum requirements that are here.

Q. But let me make sure I've got this straight. You are saying those minimum requirements are not enough?

MS. KREISEL: That is—I am going to object to putting words in her mouth.

BY MR. GILBERT:

Q. If that is not what you are saying, please let me know.

A. That is not what I am saying.

Q. What are you saying?

A. That these don't govern all aspects of a [115] person's performance, carrying out his or her position in a facility.

Q. Are there any other rules and regulations, State laws, Federal laws that you are aware of that do govern the performance of the providers in the facilities?

A. Minimally, there are certain qualifications we all have to have in our own individual area; and to a certain extent, they govern—they allow us to do certain things. But it doesn't necessarily mean that everybody has the same integrity.

Q. And the same abilities?

A. Right.

Q. And the same knowledge? Would that be included, do you think, too?

A. Same recall.

Q. I show you a document which we will mark as Exhibit 2—

(The documents were thereupon marked Ramsay Deposition Exhibit No. 2, No. 3 and No. 4 for identification, as of 11/15/85.)

BY MR. GILBERT:

Q. Show you what's been marked as Deposition [116] Exhibit 2, which is a handwritten note dated September 29, 1980, to R.F. Bilstein from Norma Van Zyl and Mary Jane Ramsay re: the Midwest Population Center.

Are you familiar with that document?

A. I don't recall the document.

Q. Did you write this document?

A. It would appear to be my handwriting versus Norma's handwriting.

Q. The document says, "Due to the size and shape of the present operation, the variations to the physical plant would appear to be reasonable".

Do you know why you wrote that or did you write that?

A. I said this appeared to be my handwriting.

Q. So you may—

A. There must have been some question.

Q. Maybe we can help. We can clear this up a little bit.

Why don't you look at Exhibit 4. I will show you Deposition Exhibit 4 for identification which is a two page document that says at the top "State of Illinois Department of Public Health Survey Report", and your name as listed as the surveyor, [117] dated August 18, 1980 regarding the Midwest Population Center. Your name is also listed on the second page at the end.

Is this a report that you completed?

A. I didn't do this report, I don't believe. I undoubtedly was on the survey with Miss Goldfarb.

Q. Your name is on there?

A. Because we did a joint survey and—but my name is misspelled on here so I don't think that I dictated this.

Q. But with your name on it, it means you were—this report represents your thinking and input with regard to that particular facility at that time?

A. Yes.

Q. Is this a typical survey report? In that it lists some deficiencies and you informed the Department of them?

A. If there was a particular question—and in 1980, I don't recall whether the architects were going out to ASTCs.

Q. So at that time, you may have been actually monitoring the physical plant requirements, as well?

A. Only if we saw a problem.

[118] Q. Let me show you Exhibit 3 for identification which is a one page document with the State of Illinois listed at the top. It is really two memos, both dated September 23, 1980 and your name appears in the upper right hand corner.

A. I did not write the memo.

Q. It was written to you, wasn't it?

A. Oh.

Q. Isn't your name there Mary Jane Van—Norma Van Zyl and Mary Jane Ramsay from Mr. Bilstein?

A. Right.

Q. Okay. And then you—let's go back to Exhibit 2 now, which—that apparently is a response to that, isn't it?

A. I can't say definitely, but since both memos contain the facility name—

Q. The Exhibit 3 from Mr. Bilstein and he says to you and Norma, "Please give me your comments on the attached letter" regarding the facilities.

And I guess the real question, "Does the facility meet requirements in an acceptable manner commensurate with activity?"

And then your Exhibit 2, which appears to be a response, says, "Due to the size and shape of the [119] present operation, the variations to the physical plant would appear to be reasonable".

A. That is what it says.

Q. That seems to be a response?

A. That would appear to be.

Q. Okay. And when you look at these three documents together, particularly Exhibit 4, it seems pretty clear, doesn't it, that the Midwest Population Center did not meet the physical plant requirements to the letter of the ASTC regulations?

A. It would appear they had some deficiencies.

Q. And you recommended that they still be found in substantial compliance because the variations were reasonable?

A. That is not what this said. I said it appeared because of the size and scope of the present operation that the variations in their plant appear to be reasonable.

Q. Despite—what does that mean in terms of their compliance with the regulations?

Are you suggesting—isn't that in effect a recommendation that they still be licensed despite their not meeting the letter of the physical plant requirements?

[120] A. It would be up to Springfield to decide whether they could be licensed. Norma and I apparently felt—since we wrote this jointly, even though I am the scribe—apparently felt with the number of procedures that were being done and the types of procedures that were being done, that the patient's health and welfare was not in danger due to the size of the rooms.

* * * * *

PLAINTIFFS' EXHIBIT NO. 25
TELEPHONIC EVIDENCE
DEPOSITION OF WILLIAM DILTS

Direct Examination by Ms. Connell

[7][1] * * * Q. Sure, go ahead.

A. The Medical Arts Building previously had been owned by the hospital; and when the hospital went through corporate restructuring, had transferred a number of assets to other corporations; one of which was the Rockford Services Company.

The Medical Arts Building was transferred at that time. We, in the hospital, have been talking about expanding and renovating the Medical Arts Building for a period of four years, at least, and had been talking about it before then.

When it was transferred over to the Rockford Services Company, the Board of Rockford Services Company is a completely different Board and group of people than the hospital Board; and when we went to that new Board, brought up the renovation and expansion of the Medical Arts Building, that Board wanted to go back to ground zero and say, "Why are we doing this? What are our objectives?" et cetera, et cetera.

Now, as we were looking somewhere between the two and a half or three million dollar project and up [8] to a four million dollar project, which went back and went to the medical purposes of why it existed.

It existed to doctors who admitted patients to Rockford Memorial for the type of lab and x-ray, to directly support their activity.

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[1] Numbers in brackets refer to the Court Reporter's original pagination of the Transcript of Proceedings.

As we got talking about the Northern Illinois Women's Center and whether or not it met that objective, which it was the opinion of the Board that it did not, the situation with the Northern Illinois Women's Center was further compounded by the fact that it is classified as an Ambulatory Surgical Treatment Center; and as a result of it being classified as an Ambulatory Surgical Treatment Center, through the entire renovation process, entire project for new construction and parts of renovation of the existing building as well as the specific space for the Northern Illinois Women's Center into a separate code, for licensing code and construction code, in terms of fire protection and electrical services, et cetera.

Q. By that, do you mean the regulations that were promulgated by the Illinois Department of Public Health and are codified in the Ambulatory Surgical Care Treatment Act?

[9] MR. FLAHAVEN: Objection, leading.

BY MS. CONNELL:

Q. Go ahead.

A. Both of the documents in front of me that I am referring to, one of them is the Rules and Regulations for the Ambulatory Surgical Treatment Center published by the Illinois Department of Public Health, and it has an effective date of July 23, 1979.

That is one of the documents. The second document is the Life Safety Code Handbook, second edition put out by the National Fire Protection Association.

Q. Mr. Dilts, directing your attention to the letter of March 5, 1985 and the fourth paragraph—

A. Yes.

Q. —I would like you to look at the—let me read one of the sentences.

"Second the Northern Illinois Women's Center is classified as Ambulatory Surgical Treatment Center by the Illi-

nois Department of Public Health. Because of this, its presence in the Medical Arts Building during construction and renovation would mean that the entire building would have to be designed to meet [10] the Illinois Department of Public Health code requirements for an Ambulatory Surgical Treatment Center. The code requirements for Ambulatory Surgical Treatment Center are much more restrictive for professional office buildings."

Mr. Dilts, can you explain to me what you meant by the code restrictions are more restrictive than that for the regular office building?

A. I can give you a general overview of what it means. I can't go into the specific details, but I can discuss with you the types of things I am talking about.

For the Ambulatory Surgical Treatment Center, it is my understanding that we would have to provide emergency power services, emergency electrical power services. That is one issue.

We would have to provide special one hour separation of the new facility from the old facility. We would have to provide an upgraded fire alarm and fire detector system throughout the building. We would have to provide—different types of smoke compartments and special smoke dampers which are the parts of the duct work. We would have to have some kind of an automatic fire extinguishing system in the [11] building.

That is the type of stuff I am talking about with the fire code and with the building code.

Now, when we get into the—

Q. Can I ask you a couple other questions?

Were there any other requirements such as air flow requirements or size of rooms or corridors that you would have had to add as a result of the Ambulatory Surgical Treatment Center?

MR. FLAHAVEN: Objection, leading.

MS. CONNELL: Deposition.

MR. FLAHAVEN: Evidence deposition.

BY MS. CONNELL:

Q. Go ahead and answer the question.

A. I was going—when you interrupted me, I was going to say that it is one issue.

The second issue is the specific requirements of the Ambulatory Surgical Treatment Center itself.

Q. Would you explain the specific requirements of the Ambulatory Surgical Treatment Center itself?

A. Again, I can't give you specifics, but I can tell you the type of thing I am talking about.

For example, the Ambulatory Surgical [12] Treatment Center required higher quality and higher grade of air handling system than does a common office building.

Specifically, I am referring to, as I understand it, the number of turnovers of air per hour that is required for an Ambulatory Surgical Treatment Center versus the number of air turnovers required for a normal office building. It also requires a much higher grade of filtration, air filtration for cleaning particles of air, et cetera, et cetera.

So that is something it effected.

We also know that the types of things that go into an office building or into an Ambulatory Surgical Treatment Center are different than go into a common office in terms of cleanants of utility rooms, recovery rooms, holding areas, changing areas, that type of thing that adds square footage to the required space.

Q. Did you ever have anyone make a cost estimate or did you do a cost estimate of what these Ambulatory Surgical Treatment Center requirements would add to the cost of renovation or construction?

A. I had two different cost estimates prepared. [13] I had one that was prepared by hospital director of engineering, and I had asked him in February to try to come

up with just what I call a gross estimate, an approximation of the cost impact that keeping the Northern Illinois Women's Center would have on our project, and when I say "gross estimate," I was interested in knowing are we talking about, you know, 500,000, 600,000, or are we talking about 100,000, 150,000.

I was looking for ballpark figures.

Using the two documents that I mentioned earlier, the Fire Code and the Licensing Act Regulations, and just some estimates of what it has cost us to do things around here, he came up with a cost of $240,000 for all the life safety fire code requirements, or requirements in the Licensing Act that are related to things like electrical, emergency power.

Now, on top of that, I put an estimate cost of approximately $90 and square foot to cover the construction and the air handling system, and so that brought it up on the basis of a 4,000 square foot area for the Northern Illinois Women's Center, which again was just a guess of what we thought it would [14] be.

It came out to be a $600,000 impact of which some of that $240,000 would be for bringing the existing building up to code or things that we have to do in the new building because of the Northern Illinois Women's Center.

The second thing I did, and I did this in May and June, was I asked the architect who was designing the expansion and renovation which was C. Edward Ware Associates, Inc., to give me his estimate of what it would take to keep the Northern Illinois Women's Center in the building.

What had happened between the February-March time frame and the May-June time frame was that we were in the process of developing the building, so we had better get an idea of what the expansion was going to look like

and more detail about what we would need to do to keep the Northern Illinois Women's Center in the building.

Q. Did Mr. Ware give you an estimate of what it would cost to keep the center in the building?

A. Yes.

He estimated between 4,800 and 5,400 square feet. Based on the volume of the center, the number [15] of employees and his interpretation of the codes and the Licensing Act that I earlier referred to, what would be needed to meet those requirements, and he came up with an estimate—he gave an estimate of cost. He gave a range.

In his opinion was between $127 and $140 per square foot.

Q. For a gross cost of approximately what, Mr. Dilts?

A. He gave a range again of between $841,766 and $973,184 to keep Dr. Ragsdale and the Northern Illinois Women's Center in the building.

And on top of that, he put an estimate additional cost of 84,000 for architectural fees.

Q. Did these cost estimates have any impact on the Board's decision to renew Dr. Ragsdale's lease?

MR. FLAHAVEN: Objection, leading.

BY MS. CONNELL:

Q. Would you answer the question, please?

A. I think really not. I think we go back to the first point that I made and the reason, the fundamental reason that Dr. Ragsdale from the Northern Illinois Women's Center was not renewed because it is not consistent with the use of the [16] building, and the use of the building is to provide space for physicians who admit patients to the hospital.

Now, five years ago, when we were running 95 percent occupancy, that was quite frankly less of a consideration

about the use of the building. The objective of the building was to fill it, to get the rent.

But now, all hospitals, and we included have seen a substantial drop in occupancy, and so that is the thing that was driving the decision.

Now,—

Q. Does Dr. Ragsdale refer patients to the hospital, Mr. Dilts?

A. He does, but he refers very few patients to the hospital out of the abortion clinic. I don't know how many he has admitted after procedures. I am not aware of any.

It is certainly very few or I would have heard—I think, on occasion he brought some to the emergency room, but that was the fundamental reason.

Incorporated into all of the discussions we were having about the objective use of the building or the objectives of the building and what its use [17] should be was also the discussion of the costs.

You know, without the former, it is possible that they would have said it is just not worth that much money to keep a tenant in the building particularly when that tenant has a requirement for such specialized design space.

I can't say that was the reason his lease was not renewed. It didn't get to that point. Had it gotten to that point, I don't know what they would have done.

Q. Who was on the Rockford—just a second, Mr. Dilts.

(An off-record discussion was had.)

BY MS. CONNELL:

Q. Mr. Dilts, did you attend the Board meeting, of the Rockford Memorial Services Corporation when Dr. Ragsdale's lease was discussed?

A. It is not Rockford Memorial Services Corporation. It is Rockford Services Company.

Q. Did you attend the Board meeting of Rockford Services Company, Mr. Dilts, when Dr. Ragsdale's lease was discussed?

A. Yes, I did.

Q. Mr. Dilts I just have a couple more [18] questions.

The compliance with the code requirements that we have been discussing this morning in terms of fire alarms emergency power backup and the air flow system, would you have been required to make those renovations in this Rockford Services building for your physicians who maintain offices there who are not an Ambulatory Surgical Treatment Center?

A. No. It's my understanding we would not have. It is my understanding an office building with physicians in it, the code requirements are identical to any professional office or office building that would have any other type of people in it.

There is no difference whether they be insurance salesmen or attorneys or whatever.

Q. Mr. Dilts, the letter of March 5, 1985—

A. Yes.

Q. —did you write that letter?

A. Yes.

Q. And is that your signature on page 2 of that letter?

A. No, it is not my signature. It is my secretary's signature, I think. Yes, it is my secretary's, but I wrote the letter.

* * * * *

Cross-Examination by Mr. Flahaven

[30] * * * Q. So it is your interpretation that the Rockford Services Company as the landlord rather than the Northern Illinois Women's Center as tenant would have to pay for these costs that we have just talked about?

A. It was our interpretation that we would have to provide a facility that would meet these code constructions and requirements and to do so would have cost us, depending which estimate I read, 600, 800 or 900,000 dollars to do that.

Q. So then it is also your understanding that all the other spaces, meaning all the space other than that occupied by the Northern Illinois Women's Center would also have to comply to all of the [31] regulations promulgated by the Department for Ambulatory Surgical Treatment Centers?

A. No, I didn't say that.

When you asked me the question about paragraph 4, that is why I said a more correct statement in paragraph 4 would have been the entire building would have had to have been brought into compliance with certain of the codes.

Specifically what I am referring to, there are the air-handling codes that I talked about earlier with the filtration and the cubic feet of air turnover per hour, would not have had to be the same for the rest of the building, but there were certain things in the building that would have been general in nature like the fire walls or some of the fire walls I am talking about, some of the smoke detection and fire safety stuff, et cetera, that would have had an impact on the cost of the remainder of the building.

* * * * *

APPELLANT'S BRIEF

No. 88-790

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, et al.,

Appellants,

v.

RICHARD M. RAGSDALE, M.D., et al.,

Appellees.

On Appeal From The United States Court Of Appeals For The Seventh Circuit

BRIEF FOR APPELLANTS

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JURISDICTION POSTPONED JULY 3, 1989

QUESTIONS PRESENTED

1. Whether this Court has appellate jurisdiction pursuant to 28 U.S.C. Section 1254(2) where the Court of Appeals judgment held unconstitutional and struck down the challenged State statutes and regulations as applied to first and early second trimester abortions.

2. Whether Illinois can constitutionally license and regulate outpatient surgical facilities in which abortions are performed to the same extent it licenses and regulates outpatient surgical facilities in which abortions are not performed.

3. Whether a case or controversy existed with respect to the challenged statutes and regulations which were not being enforced by the State of Illinois prior to the filing of the complaint.

4. Whether statutes and regulations establishing standards for the construction, maintenance and operation of outpatient surgical facilities are constitutional as applied to outpatient surgical facilities in which abortions are performed.

5. Whether the federal courts can refuse to give effect to severability requirements, thereby invalidating statutory and regulatory provisions which are constitutional.

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
TABLE OF CONTENTS	ii
TABLE OF AUTHORITIES	v
OPINIONS BELOW	1
JURISDICTION	1
CONSTITUTIONAL, STATUTORY AND REGULATORY PROVISIONS INVOLVED	3
STATEMENT OF THE CASE	4
The Illinois Statutes	5
Enforcement Policies	6
Dr. Ragsdale's Surgical Facility	8
Abortion Procedures	10
The ASTC Regulations	13
a. Management, Personnel and Patient Care Regulations	14
b. Building Design and Construction Requirements	18
Dr. Ragsdale's Cost Estimates	21
The District Court Orders	22
The Court of Appeals Decision	23

SUMMARY OF ARGUMENT	27
ARGUMENT	29
A.	
THIS COURT HAS APPELLATE JURISDICTION TO REVIEW THE FINAL JUDGMENT OF THE COURT OF APPEALS	29
B.	
THE LOWER COURT LACKED JURISDICTION TO HEAR THE CHALLENGE TO THE PROVISIONS WHICH WERE NOT ENFORCED	31
C.	
THE CHALLENGED PROVISIONS DO NOT VIOLATE THE CONSTITUTIONAL RIGHT TO PRIVACY	34
1. The Abortion-Neutral Statutes And Regulations Should Be Upheld Under The Rational Basis Test	35
2. The Challenged Provisions Do Not Unduly Burden The Abortion Decision	40
a. Regulations Based Upon Generally Accepted Standards Do Not Interfere With The Abortion Decision	40
b. The Estimated Cost Of Compliance With The Regulations Is *De Minimus*	43
c. Neither The Timing Nor The Availability Of Abortions Is Unduly Restricted	44
3. The Court of Appeals Erroneously Struck Down Three Abortion-Specific Regulations	45

D.

THE COURT OF APPEALS ERRONEOUSLY REFUSED TO SEVER ANY PROVISIONS IT FOUND UNCONSTITUTIONAL 47

CONCLUSION 49

APPENDIX

A— Revised Ambulatory Treatment Center Licensing Regulations ..... A. 1

B— Excerpt from June 1, 1973 Legislative Debate, S.B. 1051 ..... A. 18

C— Report to the House Human Resources Committee, Subcommittee on Health, December 13, 1978, "State regulation of abortion clinics" .. A. 20

TABLE OF AUTHORITIES

Cases PAGE(S)

Abortion Coalition of Mich., Inc. v. Mich. Dep't of Public Health, 426 F. Supp. 471 (E.D. Mich. 1977) 38

Arcara v. Cloud Books, Inc., 478 U.S. 697 (1986) . 39

Baird v. Department of Public Health, 599 F.2d 1098 (1st Cir. 1979) 38

Barsky v. Board of Regents, 347 U.S. 442 (1954) . 35

Birth Control Centers, Inc. v. Reizen, 743 F.2d 352 (6th Cir. 1984) 37, 44

Buckley v. Valeo, 424 U.S. 1 (1976) 48

Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972) ... 46

Carey v. Population Services International, 431 U.S. 678 (1977) 40

Champlin Refining Co. v. Corporation Commission, 286 U.S. 210 (1932) 48

Charles v. Carey, 579 F. Supp. 464 (N.D. Ill. 1983) 8

City of Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416 (1983) 7, 36

City of New Orleans v. Dukes, 427 U.S. 297 (1976) 31

City of Renton v. Playtime Theatres, Inc., 475 U.S. 41 (1986) 39

Congress of Industrial Organizations v. McAdory, 325 U.S. 472 (1945) 33

Connecticut v. Menillo, 423 U.S. 9 (1975) 36

El Paso & Northeastern R. Co. v. Gutierrez, 215 U.S. 87 (1909) 47

Friendship Medical Center, Ltd. v. Chicago Board of Health, 505 F.2d 1141 (7th Cir. 1974), *cert. denied*, 420 U.S. 997 (1975) 38

Frisby v. Schultz, 108 S.Ct. 2495 (1988) 46

Green v. Mansour, 474 U.S. 64 (1985) 34

Harris v. McRae, 448 U.S. 297 (1980) 35, 37

Hedd Surgi-Center v. Turnock, 711 F. Supp. 439 (N.D. Ill. 1989), *appeal docketed*, No. 89-1977 (7th Cir. May 10, 1989) 23, 30, 39

Hodgson v. Lawson, 542 F.2d 1350 (8th Cir. 1976) . 38

International Harvester Co. v. Deere & Co., 623 F.2d 1207 (7th Cir. 1980) 33

Maher v. Roe, 432 U.S. 464 (1977) 40

Mahoning Women's Center v. Hunter, 610 F.2d 456 (6th Cir. 1979), *vacated on other grounds*, 447 U.S. 918 (1980) 38

Parham v. J.R., 442 U.S. 584 (1979) 36

Planned Parenthood v. Danforth, 428 U.S. 52 (1976) 46

Planned Parenthood Ass'n v. Ashcroft, 462 U.S. 476 (1983) 41, 42, 44

Poe v. Department of Public Health, No. 78 C 4126 (N.D. Ill. Sept. 27, 1982) 7

Poe v. Ullman, 367 U.S. 497 (1961) 33

Regan v. Time, Inc., 468 U.S. 641 (1984) 47, 48

Roe v. Wade, 410 U.S. 113 (1973) ..... *passim*

Simopolous v. Virginia, 462 U.S. 506 (1983) ... 42, 43

Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747 (1986) 25, 31, 45, 46

Village of Oak Lawn v. Marcowitz, 86 Ill. 2d 406, 427 N.E.2d 36 (1981) 6, 7, 8, 48

Ward v. Rock Against Racism, 109 S.Ct. 2746 (1989) 38, 47

Watkins v. Blinzinger, 789 F.2d 474 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987) 34

Webster v. Reproductive Health Services, 109 S.Ct. 3040 (1989) 33, 44, 45

Westchester Women's Health Org. v. Whalen, 475 F. Supp. 734 (S.D.N.Y. 1979) 38

Williamson v. Lee Optical Co., 348 U.S. 483 (1955) . 35

Word v. Poelker, 495 F.2d 1349 (8th Cir. 1974) .. 38

Constitutional Provisions

U.S. CONST. Amend. I 3, 4

U.S. CONST. Amend. IV 3, 4

U.S. CONST. Amend. V 3, 4

U.S. CONST. Amend. IX 3, 4

U.S. CONST. Amend. XI 3, 28, 34

U.S. CONST. Amend. XIV, Section 1 ..... 3, 4

Statutes

28 U.S.C. Section 1254(2) 2, 28, 29, 31
28 U.S.C. Section 1343 1
28 U.S.C. Section 2201 1
28 U.S.C. Section 2202 1
28 U.S.C. Section 1983 1
Ambulatory Surgical Treatment Center Act,
Ill. Rev. Stat. ch. 111½, pars. 157-8.1 *et seq.* .. *passim*
Health Facilities Planning Act,
Ill. Rev. Stat. ch. 111½, par. 1151 *et seq.* . .. *passim*
Medical Practice Act,
Ill. Rev. Stat. ch. 111, par. 4400-22 ..... *passim*

Regulations

Ambulatory Surgical Treatment Center Licensing
Requirements, 77 Ill. Adm. Code, Ch. 1,
Section 205, Subchapter b ..... *passim*

No. 88-790

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, et al.,
Appellants,

v.

RICHARD M. RAGSDALE, M.D., et al.,
Appellees.

On Appeal From The United States Court Of Appeals For The Seventh Circuit

BRIEF FOR APPELLANTS

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Seventh Circuit entered March 10, 1988 is reported at 841 F.2d 1358 (7th Cir. 1988) and is reproduced at Appendix A of the Appendix to the Jurisdictional Statement. On August 12, 1988 the defendants' petition for rehearing and suggestion for rehearing *en banc* was denied. (Jur. Appendix D, E). The memorandum opinion of the United States District Court for the Northern District of Illinois rendered November 27, 1985 is reported at 625 F. Supp. 1212 (N.D. Ill. 1985) and is reproduced at Jur. Appendix G.

The judgment order of the United States District Court entered December 11, 1985 is not reported, but is reproduced at Jur. Appendix F.

JURISDICTION

This action, brought under 28 U.S.C. Sections 2201 and 2202 and 42 U.S.C. Section 1983 challenges the constitutionality of portions of the Illinois Medical Practice Act, Illinois Ambulatory Surgical Treatment Center Act, and Illinois Health Facilities Planning Act. Invoking the jurisdiction of the District Court under 28 U.S.C. Section 1343, plaintiffs filed a class action seeking declaratory and injunctive relief. Subsequent to an evidentiary hearing, the District Court entered on November 27, 1985 and December 11, 1985 a preliminary injunction in favor of plaintiffs and enjoined enforcement of the Acts and rules promulgated thereunder to the extent any person or facility

offers or performs, or desires to offer or perform first and/or early second trimester abortions or other abortion-related gynecological procedures.

On appeal, the United States Court of Appeals for the Seventh Circuit vacated as moot one portion of the District Court's decision, held unconstitutional the other challenged provisions, and affirmed the remainder of the decision. Its judgment was entered on March 10, 1988.

On August 12, 1988 a majority of the members of the original panel voted to deny the defendants' petition for rehearing, and the suggestion for rehearing *en banc* failed by an equally divided court. Judges Wood, Posner, Coffey, Manion, and Kanne voted to grant rehearing *en banc*. (Jur. Appendix D, E).

Defendants Turnock, Hartigan and Selcke filed their Notice of Appeal in the Court of Appeals on November 7, 1988. (Jur. Appendix H). Jurisdiction of the Supreme Court of the United States to review this judgment by appeal is conferred by 28 U.S.C. Section 1254(2).

On July 3, 1989 this Court entered an order postponing further consideration of the question of jurisdiction to the hearing of the case on the merits. *Turnock v. Ragsdale*, 109 S.Ct. 3239 (1989).

CONSTITUTIONAL, STATUTORY AND REGULATORY PROVISIONS INVOLVED

Constitutional Provisions

U.S. CONST. Amend. I.

U.S. CONST. Amend. IV.

U.S. CONST. Amend. V.

U.S. CONST. Amend. IX.

U.S. CONST. Amend. XI.

U.S. CONST. Amend. XIV, Section 1.

The text of these provisions is reprinted at pages 2-4 of the Jurisdictional Statement.

State Statutes

Ambulatory Surgical Treatment Center Act,
Ill. Rev. Stat. ch. 111½, pars. 157-8.1 *et seq.*
(Reprinted at Jur. Appendix I)

Health Facilities Planning Act,
Ill. Rev. Stat. ch. 111½, par. 1151 *et seq.*
(Reprinted at Jur. Appendix J)

Medical Practice Act,
Ill. Rev. Stat. ch. 111, par. 4400-22
(Reprinted at Jur. Appendix K)

Regulations

Ambulatory Surgical Treatment Center
Licensing Requirements, 77 Ill. Adm. Code, Ch. 1,
Section 205, Subchapter b
(Reprinted at Jur. Appendix L)

STATEMENT OF THE CASE

Plaintiff Richard M. Ragsdale, M.D. is a licensed physician who performs abortions as part of his surgical practice. Plaintiff Northern Illinois Women's Center is an Illinois corporation which provides abortion services to women in the Rockford, Illinois area. Dr. Ragsdale is the Medical Director at the Center. Plaintiff Margaret Moe is a registered nurse and the sole owner of a medical clinic in Cook County, Illinois. Plaintiffs Sarah Roe and Jane Doe are female citizens of child-bearing age who alleged that they had abortions in the past and may seek abortions in the future. (J.A. 6-8).[1]

Plaintiffs' complaint alleged that the challenged statutes formed a "tripartite" regulatory scheme which impermissibly restricted the performance of first and early second trimester abortions. Specifically, plaintiffs claimed that the statutes and regulations violated rights secured by the First, Fourth, Fifth, Ninth and Fourteenth Amendments to the United States Constitution. Further, they contended that the challenged provisions, as applied, singled out for discriminatory treatment facilities in which abortions were performed. (J.A. 3-4, 21).

The defendants in the district court were Bernard J. Turnock, M.D., M.P.H., Director of the Illinois Department of Public Health; Neil F. Hartigan, Attorney General of Illinois; Gary L. Clayton, Director of the Illinois Department of Registration and Education; and Richard

[1] The Joint Appendix is referred to as J.A.
The Appendix to the Jurisdictional Statement is referred to as Jur. App.
The Appendix to this brief is referred to as A.
The trial transcripts are referred to as R.
Deposition testimony was admitted into evidence, and is referred to as Dep.

M. Daley, State's Attorney of Cook County. Turnock, Hartigan and Clayton were the appellants in the Court of Appeals. Daley did not file a notice of appeal. Appellant Stephen F. Selcke, Director of the Illinois Department of Professional Regulation, is the successor in public office to Gary L. Clayton, Director of the Illinois Department of Registration and Education.

The defendants argued that certain of the challenged provisions had not been enforced for several years in compliance with various court decisions. Thus, the challenged provisions regulated surgical facilities in which abortions were performed to the same extent they regulated facilities performing nonabortion surgical procedures. The provisions did not regulate physicians' offices or health clinics in which abortions were performed. Defendants also argued that the challenged provisions furthered substantial state interests in the health and safety of its citizens.

The Illinois Statutes

The Illinois Ambulatory Surgical Treatment Center Act [ASTC Act] became law in 1973. The Act declares the State's public policy and interest "in assuring that all medical procedures, including abortions, are performed under circumstances that insure maximum safety." The Act's purpose is to provide for the protection of the public health through the development and enforcement of standards for the construction and operation of surgical facilities which promote safe and adequate treatment. (Jur. App. 149).

ASTCs are same-day surgical facilities which are primarily devoted to the performance of surgical procedures. "Primarily" has been interpreted and held to require licensure of outpatient surgical facilities in which 51 percent of patient visits are surgical or surgically related. (R. 667-68).

The Illinois Health Facilities Planning Act [HFP Act] became law in 1974. The purpose of the HFP Act is to obtain a comprehensive health care delivery system involving all types of health care facilities, services and equipment. The HFP Act also represents an attempt to restrain the rising costs of health care by preventing unnecessary construction and duplication of unneeded health care facilities. (R. 689; Jur. App. 166). Health care facilities falling within the HFP Act's provisions include those licensed pursuant to the Health Maintenance Organization Act, the ASTC Act, the Nursing Home Care Reform Act of 1979, the Hospital Licensing Act, and kidney disease treatment centers. (Jur. App. 167).

The Illinois Medical Practice Act [MPA] enumerates licensure requirements for Illinois physicians and prohibits the practice of medicine by any person not holding a valid license. Ill. Rev. Stat. ch. 111, par. 4401 *et seq.*[2] Paragraph 4433 of the MPA provided that the Department of Registration and Education [now Professional Regulation] could discipline a physician for the performance of an elective abortion in a non-licensed facility.[3] This provision, however, was no longer being enforced by the Department of Professional Regulation. (J.A. 272-74).

Enforcement Policies

At trial, the defendants introduced evidence that four of the challenged statutory and regulatory provisions had not been enforced for several years. In 1981, the Supreme Court of Illinois decided *Village of Oak Lawn v. Marcowitz*, 86 Ill. 2d 406, 427 N.E.2d 36 (1981). In *Marcowitz*, the court considered a village ordinance which had adopted the definition of an ASTC which was found in the State ASTC Act. The Supreme Court of Illinois held that the

[2] Now, par. 4400-1 of the Medical Practice Act of 1987.

[3] Now, ch. 111, par. 4400-22(1).

ordinance was unconstitutional to the extent that it defined an ASTC to be any facility in which abortions are performed, irrespective of whether the facility is devoted primarily to that purpose. *Id.* at 420. The court severed that portion of the definition of an ASTC from the remainder of the ordinance.

Four days after *Marcowitz* was decided, the Illinois Department of Public Health, pursuant to a written policy, ceased to enforce the identical abortion-specific portion of the definition of an ASTC found in the State statute. (J.A. 241-42, 267-69; Def. Ex. 2, R. 652, 655, J.A. 48). Since 1981, therefore, ASTC licensure and enforcement proceedings were applied only to facilities primarily devoted to the performance of surgical procedures, and not to doctors' offices and health clinics.

In 1982, the United States District Court in *Poe v. Department of Public Health*, No. 78 C 4126 (N.D. Ill. Sept. 27, 1982), enjoined the Illinois Department of Public Health from enforcing Section 4 of the Illinois Abortion Law of 1975 and "any related regulation." Section 4 was a second trimester hospitalization requirement. The Department determined that this ruling also enjoined the enforcement of ASTC regulation 205.740 (Jur. App. 222) which prohibited the performance of second trimester abortions in ASTCs. (R. 655-56; Def. Ex. 3, R. 655, 658).

In 1983, this Court decided *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983). The decision in *Akron* reinforced the earlier district court order, and the Department's policy of not enforcing Section 205.740 continued. (R. 657-58, Def. Ex. 4). In December of 1982 or January of 1983, Dr. Ragsdale was informed by telephone that Section 205.740 was no longer being enforced. As a result, Dr. Ragsdale began to perform early second trimester abortions at his facility. (R. 148-49).

In *Charles v. Carey*, 579 F. Supp. 464 (N.D. Ill. 1983), Section 10 of the Abortion Law of 1975 (the reporting requirement) was permanently enjoined. Since that time, Section 205.760 (Jur. App. 223), an abortion specific reporting requirement, has not been enforced. (J.A. 242-43). Dr. Ragsdale testified that the Department of Public Health notified him by telephone and personally that this section was no longer being enforced. (J.A. 133-35).

The Illinois Department of Registration and Education [now Professional Regulation] has absolute prosecutorial discretion over the initiation of disciplinary actions under the MPA. Because of the *Marcowitz* decision and other decisions concerning the abortion issue, the challenged portion of the MPA (Jur. App. 193) was and is not being enforced by the Department to restrict the performance of all abortions to licensed facilities. (J.A. 272-74). In addition, plaintiff Moe testified that she was personally aware of and had assisted two Illinois physicians who performed abortions in their offices. (J.A. 271).

Dr. Ragsdale's Surgical Facility

At the time of the 1985 trial, there were 42 licensed ASTCs in Illinois. (J.A. 241). The types of surgical procedures performed in licensed ASTCs include plastic surgery, removal of cysts and tumors, pregnancy terminations, tubal ligations, hernia repairs and rhinoplasty repairs of the nose. (R. 764). Of the 42 licensed ASTCs, 22 had indicated to the Illinois Department of Public Health that the surgeries performed would include abortions. (J.A. 241). Dr. Ragsdale's facility was one of the licensed facilities which performed abortions.

In 1973, Dr. Ragsdale opened the Northern Illinois Women's Center. The Center primarily provided first and early second trimester abortion services. (R. 40). Dr. Ragsdale testified that he performed approximately 3,500

abortions per year. For the 12 years prior to trial Dr. Ragsdale had performed in excess of 42,000 abortions. (R. 43). During that time, Dr. Ragsdale was the primary abortion provider in Northwestern Illinois. (R. 34). Dr. Ragsdale is well known as a provider of abortion services in the Rockford, Illinois area. (R. 508, 541; J.A. 231).

The primary procedure used by Dr. Ragsdale for first trimester abortions is suction curettage, a procedure which lasts approximately eight minutes. (R. 44; J.A. 67). Dr. Ragsdale uses the dilation and evacuation procedure for early second trimester abortions. (R. 501-02). Out of the more than 40,000 abortion procedures performed by Dr. Ragsdale, 24 patients had major complications which required hospitalization. (J.A. 78). Minor complications occurred in 1.3 to 2 percent of the cases. (J.A. 79).

Prior to trial, Dr. Ragsdale's facility had been licensed as an ASTC for 12 years under the challenged statutes and regulations. The facility contained variations from the ASTC regulations. Any such variances did not substantially affect renewal of Dr. Ragsdale's license for those 12 years. (J.A. 85-86, 94).

The landlord of Dr. Ragsdale's outpatient surgical facility was the Rockford Memorial Hospital. (R. 352). On February 1, 1985 Dr. Ragsdale was notified both orally and in writing that his lease would not be renewed. (R. 353). In September of 1985, he was informed by letter that he was to leave the premises by December 31, 1985. (R. 355; Pl. Ex. 15, R. 356, 425-26, 611).

The nonrenewal of Dr. Ragsdale's lease was a result of the landlord's decision to expand and renovate its building and the landlord's desire to have, as tenants, doctors who admitted patients to Rockford Memorial Hospital. It was determined that Dr. Ragsdale's facility was not consistent with that desired use of the building. The ASTC Act and estimates of the cost of compliance with the Act

had no impact on the hospital board's decision not to renew Dr. Ragsdale's lease. (Pl. Ex. No. 25, R. 778-79; Dilts Dep. 7-8, 15-16). Had the hospital board considered any cost issues, it is unknown what would have been done. (Dilts Dep. at 17).

The Illinois Department of Public Health preliminarily approved Dr. Ragsdale's plans for relocation of his facility. (R. 180-81). In addition, Dr. Ragsdale submitted an application for a certificate of need. (J.A. 123). The application included a cost summary and a representation that no fee increase for abortion procedures was anticipated as a result of the move. (Pl. Ex. 11, R. 195, 425-26, 600-01). On March 14, 1985, Comprehensive Health Planning of Northern Illinois (CHPNI) held a public meeting regarding the proposed relocation. CHPNI is a federally funded organization which is a separate entity from the HFP Board. It is responsible for completing an independent review of a proposed project. (R. 200, 683-85).

Dr. Ragsdale attended the CHPNI meeting. There were, in Dr. Ragsdale's opinion, some "rational" discussions and some statements supporting the need issue. There were also statements that there was no need for the facility. Dr. Ragsdale testified that the meeting degenerated into a shouting match over abortion. (R. 200-02).

Dr. Ragsdale was subsequently informed by CHPNI that his proposal met the review requirements, including the need requirement. However, the lease which Dr. Ragsdale had procured was withdrawn by the proposed lessor. A final decision on the proposed site, therefore, was not rendered by the various agencies. (J.A. 130-31).

Abortion Procedures

According to the plaintiffs' expert witness, Dr. Warren Hern, there are few surgical procedures given so little

attention and so underrated in its potential hazard as abortion. (J.A. 218). Dr. Ragsdale testified that not all licensed physicians have the qualifications, training and experience to perform safe first and early second trimester abortions. (J.A. 159).

Moreover, medical education in this country has paid little attention to abortion services. (J.A. 209). Abortion, more than any other type of procedure, requires much experience and practice. It is not a procedure which can be done well after a few hundred or even a few thousand procedures. (J.A. 212).

The major complications resulting from abortions are perforation of the uterus, hemorrhaging, and infections. (J.A. 284, R. 506). These complications are also associated with the insertion of intrauterine devices [IUD] and the performance of diagnostic dilation and curettage procedures. However, the complications are much more serious and profound in the abortion context than in the diagnostic D&C or the insertion of an IUD. (J.A. 168, 282-83).

The seriousness of the complications stems from the pregnant state of the uterus. It is larger, filled with products of conception, and softer. As a result, the pregnant uterus is perforated more easily and hemorrhages can be much more severe. The incidence of infection is also higher with abortion than with insertion of an IUD or a diagnostic D&C. In addition, there is a higher complication rate for first trimester abortions than diagnostic D&Cs. (J.A. 168-69, 282-84).

There are several factors which affect the safety of first and early second trimester abortions. One factor is the skill, experience and professional integrity of the physician performing the abortion. (J.A. 82, 184; Def. Ex. 7, R. 780, Barton Dep. 101-02, 104, 107). Given the appropriate instruments, a skillful and experienced operating physician can perform the abortion procedure with great

safety. The necessary skill is developed by observation, performance of the procedure under the supervision of a skilled and experienced physician, and through much practice. (J.A. 184-85).

Another significant factor is the duration of the pregnancy. (J.A. 82, 185). Starting from five weeks and continuing through 12 weeks of pregnancy there is a slow linear increase in the rate of death and major complications associated with abortion. From the 14th week this increase in complications accelerates. (J.A. 83, 185).

The choice of abortion technique is another major factor affecting the safety of the abortion procedure. (J.A. 82-83, 186). The most widely used abortion procedure during the first trimester is suction curettage. The dilation and curettage procedure is still used by some physicians, and has a higher morbidity rate than the suction curettage method. (J.A. 83, 186).

The principal technique used for second trimester abortions through the 15th week is dilation and evacuation. (J.A. 187-88). Other methods used are saline, urea and prostaglandin installation techniques. (J.A. 186). The complication rates for the dilation and evacuation method are lower during the 13 to 20 week period than the complication rates for the installation methods. (J.A. 187).

Another factor influencing the safety of first and early second trimester abortions is the type of anesthesia used. The use of a local anesthesia is safer than a general anesthesia. (J.A. 84, 180-81). Dr. Ragsdale has never used a general anesthesia on an outpatient basis. (R. 503). There are clinics in this country in which general anesthesia is the principal method of anesthesia used in the performance of outpatient abortions. (R. 322). There were abortion procedures performed under general anesthesia in Illinois in licensed ASTCs. (R. 764).

Other factors influencing the safe performance of abortion procedures include the existence of sterile conditions, availability of qualified staff and appropriate equipment, and the availability of emergency facilities. (Def. Ex. 7, Barton Dep. 101, 107, 111-12, 143, R. 780).

The ASTC Regulations

Plaintiffs' expert witnesses, both licensed physicians, testified generally that the ASTC regulations are not medically necessary for the performance of a safe first or early second trimester abortion.[4] (J.A. 84-85, 196). Certain components of the regulations, however, were acknowledged to be consistent with safe and acceptable standards of medical care. (J.A. 213-14). Some regulations were described as belaboring the obvious, the kind of thing any competent practitioner would do, superfluous, and "the sort of thing that will be accomplished when something is properly constructed." (J.A. 95-96, 103, 120, 214).

The ASTC Act provides that licensure may be denied if there has been a determination after notice and an opportunity to be heard that the facility fails to substantially comply with the Act or regulations. (Par. 157-8.7, Jur. App. 155-57). Section 205.1320(b) of the ASTC regulations provides that the sponsor for the project is to submit a narrative program describing the functions of the facility. (Jur. App. 225). This narrative includes space requirements, staffing patterns and the types of surgery and procedures performed. Determinations as to substantial compliance with the ASTC Act and regulations are based upon the program submitted by the provider. (Linder Dep. 42, 57-58, Def. Ex. 9, R. 782).

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[4] Subsequent to trial, the Illinois Department of Public Health revised some of the regulations. The revised regulations are reprinted in the Appendix to this brief. (A. 1-17).

a. Management, Personnel And Patient Care Regulations

A considerable portion of the evidence involved management, personnel and patient care regulations. For example, section 205.240 provides that the facility is to formulate a written policies and procedures manual. (Jur. App. 213). Dr. Ragsdale described this requirement as standard medical and administrative practice. (J.A. 100-01).

The Standards for Obstetric-Gynecologic Services of the American College of Obstetricians and Gynecologists, Sixth Edition [ACOG standards] provide that in physicians' offices and outpatient clinics, as well as in free-standing ambulatory surgical facilities, specific plans and procedures for the health and safety of patients and personnel should be developed. (J.A. 59, 62-63; R. 760, 762). Section 205.510 provides that each licensed ASTC should have written safety plans. (Jur. App. 216).

The ACOG standards also provide that a free-standing ambulatory surgical facility should have a governing body similar to a hospital board of trustees that has final authority and responsibility for patient care, facilities, services, appointment of the medical staff, and delineation of clinical privileges. (J.A. 50). Section 205.230(a) provides that the management of a licensed ASTC is to appoint a qualified consulting committee. (Jur. App. 211-13). Dr. Ragsdale testified that this regulation is "belaboring the obvious" and reminds him of the tissue committee and credential committee in a hospital. (J.A. 95-96, 98-99).

The ACOG standards provide that clinics and free-standing ambulatory care facilities in which abortions are performed should have written agreements with nearby hospitals, in the event of complications. (J.A. 54). Plaintiffs' expert, Dr. Hern, testified that either the medical director or principal physician should have staff privileges at the nearest hospital, or there should be a hospital transfer agreement. (J.A. 222). Section 205.540(c) provides that

there should be written documentation of either a transfer agreement, a statement that the medical director has admitting privileges, or that each staff physician, podiatrist or dentist has admitting privileges. (Jur. App. 218).

In settings in which preoperative evaluations, including laboratory studies, patient history and complete physical examination, are perfunctory or absent, diagnostic errors in gestational length are more likely. This may result in serious complications. (R. 319). Section 205.520(b) provides that a complete medical history shall be taken and the physical examination shall be complete. (Jur. App. 216-17).

In a non-profit or lay operated clinic, the medical director is responsible and liable for all actions taken with regard to patients. Dr. Hern testified that if the clinic has no medical director, the responsibility and liability for medical decisions may rest with individuals who have no understanding or professional experience with these responsibilities. The patients are likely to suffer under such circumstances. (J.A. 221). Section 205.230(b) provides for designation of a Medical Director who shall have supervisory responsibilities, and is to ensure compliance with policies and procedures. (Jur. App. 213).

Subpart G of the regulations sets out additional requirements for facilities in which obstetrical or gynecological procedures are performed. (Jur. App. 220-23). Most of the abortion-specific provisions are contained within this subpart.[5] Plaintiffs' expert, Dr. Hern, testified that there are

[5] Many of the regulations were passed in 1979 and address concerns raised by State legislators. Those issues are reflected in recommendations contained in a report of the Illinois General Assembly's Subcommittee on Health. (A. 20-53). That Subcommittee developed its recommendations for regulations in light of a *Chicago Sun-Times*-Better Government Association investigation which exposed numerous abuses in abortion clinics. In addition to specific recommendations, the Subcommittee criticized the State for failing to aggressively regulate such facilities. (A. 23).

aspects of Subpart G which are consistent with good standards of medical practice. (J.A. 211).

The ACOG standards provide that ambulatory care facilities for abortion services should meet the same standards of care as for other surgical procedures. (J.A. 54). Section 205.710 contains a similar provision. (Jur. App. 220). Expert witnesses, Drs. Ragsdale and Barton, both agreed with this provision. (J.A. 103; Barton Dep. 160, Def. Ex. 7, R. 780).

Counseling is an indispensable part of a thorough preoperative evaluation and preparation of a patient for an abortion procedure. (J.A. 218). In Dr. Ragsdale's practice, the patient is provided with counseling prior to the abortion procedure. (J.A. 72). In general, the same counseling is provided to each patient. According to plaintiffs' expert, Dr. Hern, counseling should include a discussion of the alternatives for dealing with pregnancy. (J.A. 210-11). Likewise, the ACOG standards state that prior to an abortion, "the woman should be counseled on the options for management of an unwanted pregnancy." (J.A. 55). Section 205.730(b) provides that counseling is to be provided prior to obstetrical or gynecological procedures following diagnosis of pregnancy, and that counseling "shall include a discussion of alternatives, description of the procedure to be performed, explanation of risks and possible complications." (Jur. App. 221-22).

According to plaintiffs' expert, Dr. Hern, first trimester abortion patients should remain at the facility approximately one hour from the time they arrive in the recovery room. (J.A. 219). Section 205.540(a) provides that patients who have had general anesthesia, local anesthesia with sedation or a pregnancy termination are to be observed for a period of time sufficient to ensure that no immediate postoperative complications are present. Under that regulation, no patient shall be required to leave the

facility in less than one hour following the procedure. (Jur. App. 218). That section is consistent with minimum standards of good surgical treatment. (J.A. 174-75).

Careful reports of abortion procedures are essential to public health evaluation. (R. 318). This includes official reports to State agencies, such as the reports Dr. Hern submits in Colorado, and is required in other States. Such reports are compiled quarterly. (R. 326). Section 205.620 requires all ASTCs to annually submit to the Department certain clinical statistical data. (Jur. App. 220).

Routine laboratory work for abortion procedures should include a urine screening exam for pregnancy, a hemotocrit or hemoglobin, an Rh screening test, dip stick urinalysis and for black patients a sickle cell test. (J.A. 54-55, 217-18). Section 205.520(b) provides that a hemoglobin or hemotocrit is to be performed prior to certain surgical procedures. (Jur. App. 216-17). Section 205.730(a) provides that prior to obstetrical procedures, blood Rh factor is to be determined and that prior to performing an abortion, the diagnosis of pregnancy is to be established. (Jur. App. 221). Dr. Ragsdale has no disagreement with these appropriate laboratory tests. (J.A. 105).

After every abortion, removed tissue should be examined. (J.A. 155-56, 218-19). One of the purposes of the pathology report is to confirm pregnancies in early stages. Another purpose is to ensure that fetal parts are present and to be able to alert patients to possibility of an ectopic pregnancy. (J.A. 55, 156). Section 205.530(c) provides that all tissues removed during surgery are to be examined by a consulting pathologist. (Jur. App. 217). Section 205.230(a)(5) provides that the appointed consulting committee shall act as tissue committee and review quarterly the pathological reports of procedures performed by each physician on the staff. (Jur. App. 213). The ACOG standards provide that in free-standing ambulatory facilities, a qualified team of

professionals should be responsible for evaluating patient care. (J.A. 60-61).

Section 205.120(b)(9)(F) requires a corporation operating an ASTC devoted primarily to providing facilities for abortion to have a licensed physician who is actively engaged in the practice of medicine at the center on its Board of Directors. (Jur. App. 210). Dr. Ragsdale testified that this regulation is not a burden to him. (J.A. 91).

There is no substitute for an on-site inspection in order to evaluate a facility in which abortions are performed. (R. 319; J.A. 253). Par. 157-8.9 of the ASTC Act provides that all licensed ASTCs are to be inspected four times per year. (Jur. App. 160).

b. Building Design And Construction Requirements

Subparts (I) and (J) of the ASTC regulations include various building design, construction standards, and physical and mechanical requirements. (Jur. App. 225-44). Dr. Hern, who does not consider himself a building design, construction, or mechanical expert, testified that the provisions of Subparts (I) and (J) are not medically necessary for the operation of a facility in which first and early second trimester abortions are to be performed. (J.A. 224-25).

Section 205.1320(d) provides that the design of a licensed ASTC is to provide for accessibility to the physically handicapped (public, staff and patients). (Jur. App. 226). Section 205.1410(d) provides that ASTCs located above the first floor of the building shall have an elevator. (Jur. App. 240). Dr. Ragsdale is of the opinion that these requirements are not medically necessary. (J.A. 121-22, 157-59). One-tenth of one percent of the persons using Dr. Ragsdale's facility are disabled. Dr. Ragsdale testified that on the occasions when it was necessary to transport handicapped patients between floors, the patients were carried. (J.A. 161-62).

Section 205.1510 provides that after building heating, ventilating and air conditioning systems are installed they shall be tested and balanced to ensure that they are in proper working condition. (Jur. App. 240). The regulation also provides that upon completion of the facility, the owner of the ASTC is to be provided with operating and maintenance instructions. According to defendants' expert witness, an engineer, these provisions reflect common, accepted and standard practice. (J.A. 226-28).

Section 205.1520 provides, among other things, for insulation in the facility and in certain situations for a flame spread rating in accordance with the National Fire Protection Association. (Jur. App. 240-41). These requirements reflect general standards found in various types of buildings, including offices and health facilities. (J.A. 228).

Section 205.1530 reflects certain requirements relative to steam and hot water systems. (Jur. App. 242). These provisions are not unusual, and reflect good engineering practice. (J.A. 229).

Section 205.1540(f) sets forth certain pressure and rate requirements for the ventilation system. (Jur. App. 242). Table A, which describes pressure relationships and air changes, can be compared to the requirements of hospital regulations. (Jur. App. 250). The requirements of the ASTC regulation are less stringent than those required in hospitals. (R. 736-39).

Section 205.1540(h) provides that ASTCs are to be equipped with systems having certain filter efficiencies. (Jur. App. 243). The requirements are identical to the standards of the American Society of Heating, Refrigeration and Air Conditioning Engineers, and are usual requirements. (R. 739-40). Section 205.1540 provides for additional items which are standard. (R. 740-43).

Section 205.1620(a) and (b) set forth certain plumbing fixture requirements. (Jur. App. 244). The requirements are also standard. (R. 743-44; J.A. 300).

The ACOG standards provide that in physicians' offices and in outpatient clinics, examining rooms should be equipped with handwashing facilities and paper towels, an exam table, equipment, a desk, table or shelf for writing and a storage cabinet. (J.A. 57-59). Section 205.1360(a) provides that examination rooms should be equipped with handwashing facilities and a space for writing. (Jur. App. 231).

Section 205.1360(b) provides that at least one procedure room should be 250 square feet. (Jur. App. 232). This requirement was determined with procedures involving general anesthesia in mind. (J.A. 298). Two of Dr. Ragsdale's procedure rooms were 120 sq. ft., and the third was smaller. (R. 82-83). This variance was allowed by the Department, due to the nature of Dr. Ragsdale's facility. (Pl. Ex. 20, p. 6, R. 411, 614). Dr. Hern is of the opinion that there is no medical necessity for a 250 sq. ft. procedure room. (J.A. 200-01).

Section 205.1400(a) provides that public corridors are to be 5'0" wide, except that where patients are transported in stretchers corridors shall be 8'0" wide. (Jur. App. 236). If the practitioner does not envision the use of stretchers, then corridors need not be 8'0" wide. (Linder Dep. 24-25, Def. Ex. 9, R. 782). Dr. Hern is of the opinion that there is no medical justification for this regulation. (J.A. 204).

Section 205.1400(n) provides for minimum ceiling height of 8'0". (Jur. App. 237). This is a universally accepted minimum. (J.A. 299-300).

Section 205.1320(a) provides that a licensed facility is to be identifiably separate from other facilities and functions. (Jur. App. 225). In other words, corridors, walls and doors should separate the facility from the rest of the business

occupancy. A separate building entrance for the ASTC is not required. (Linder Dep. 56-65, Def. Ex. 9, R. 782). Dr. Hern is of the opinion that this provision is not medically necessary. (J.A. 198).

Dr. Ragsdale's Cost Estimates

In order to aid his testimony at trial, Dr. Ragsdale determined what it would cost on a rough basis and in broad terms to comply with the ASTC Act and regulations. (J.A. 138, 140). Dr. Ragsdale prepared, at the request of his attorney, two documents reflecting his estimates of the costs of moving his practice to a new location and to comply with the ASTC regulations. (J.A. 138-39, 141; Pl. Ex. 17 and 18, J.A. 35).

Defendants objected to the admission of the cost estimates on hearsay grounds. (J.A. 139, 162-63). The district court overruled the State's objections, and admitted the cost estimates. (J.A. 163-64).

In order to estimate cost, Dr. Ragsdale spoke with contractors, plumbing people, heating people and vendors. (J.A. 141, 156). Dr. Ragsdale first estimated the cost of relocation of his practice as a result of the loss of his lease, and without complying with the ASTC Act and regulations. (J.A. 141-43; Pl. Ex. 17, J.A. 35). Dr. Ragsdale concluded that the cost would be an additional $22.45 per patient per year. That cost could be absorbed or could be covered by increasing patient fees. (J.A. 144; Pl. Ex. 17, J.A. 35).

Dr. Ragsdale prepared a second estimate which represented his guess as to what it would cost in addition to his own relocation expenditures in order to bring his new facility into reasonable compliance with the ASTC regulations. (J.A. 144-45). Dr. Ragsdale estimated that the cost would be an additional $25.21 per patient per year. (J.A.

146; Pl. Ex. 18, J.A. 35). Dr. Ragsdale testified that this additional expense would be passed through to his patients. (J.A. 146). However, the remodeling expense reflected in the handwritten estimate would be retired after two years. (J.A. 159; Pl. Ex. 18, J.A. 35).

The District Court Orders

The trial conducted by the district court was held on November 18-22 and 26, 1985. Subsequent to trial, the district court certified the following classes: (a) a plaintiff class of physicians and surgeons who perform or desire to perform abortions in Illinois; (b) a plaintiff class of all Illinois women of child-bearing age who desire or may desire an abortion sometime in the future; and (c) a defendant class of all State's Attorneys in Illinois. (Jur. App. 110).

In addition, the defendants were preliminarily enjoined and restrained from enforcing the challenged provisions of the ASTC Act and the rules and regulations promulgated thereunder, and the MPA and HFP Act to the extent any person or facility offers or performs, or desires to offer or perform first and/or early second trimester abortions or other abortion-related gynecological procedures. (Jur. App. 110-11).

In its November 27, 1985 Order, the district court found that plaintiffs had prevailed on the four traditional factors considered in ruling on a motion for preliminary injunction. (Jur. App. 129). In considering the merits of plaintiffs' claims, the district court utilized the trimester framework established in *Roe v. Wade*, 410 U.S. 113 (1973). (App. 134-35). Applying those standards to this case, the district court found that plaintiffs had demonstrated that the statutes and regulations placed a burden on a woman's right to choose to terminate her pregnancy during the first and early second trimester. Specifically, it

found that the challenged provisions (1) increase the cost and decrease the availability of abortions and (2) may delay the effectuation of a woman's decision to abort. (Jur. App. 137).

Further, the district court found that defendants had failed to produce evidence of a compelling or rational basis for the challenged statutes and regulations.[6] It noted that defendants had shown that certain regulations are consistent with accepted medical practice, but that such showing is not equivalent to a demonstration that the challenged provisions are medically necessary. Thus, the district court found a reasonable likelihood that plaintiffs would succeed on the merits. (Jur. App. 137-38).

The Court Of Appeals Decision

Defendants appealed from the district court's orders to the United States Court of Appeals for the Seventh Circuit. On March 10, 1988 that court issued its decision. (Jur. App. 1). The majority declared unconstitutional and struck the challenged provisions as applied to first and early second trimester abortions. In addition, the court affirmed, with one exception, the district court's preliminary injunction order. The exception is the challenge to one ASTC regulation—the second trimester hospitalization requirement—which the majority held was not being enforced, was moot, and should have been dismissed. Judge Coffey submitted a lengthy dissent. (Jur. App. 34-80).

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[6] The district court has since acknowledged that the portion of its opinion stating that defendants had failed to demonstrate a rational basis for the statutes and regulations is dictum. *Hedd Surgi-Center v. Turnock*, 711 F. Supp. 439, 444 n.8 (N.D. Ill. 1989), *appeal docketed*, No. 89-1977 (7th Cir. May 10, 1989). The district court has also stated that it is "unlikely" that the challenged statutes would not survive a rational-relationship challenge. 711 F. Supp. at 444.

The majority opinion first considered whether certain of plaintiffs' challenges had been mooted by the State's policies of nonenforcement. The majority found the challenge to the second trimester hospitalization requirement moot because enforcement ceased in 1983. (Jur. App. 11-13). It held, however, that the challenge to the reporting requirement of the regulations was not moot because the State had not produced pre-existing documentation of the nonenforcement policy. (Jur. App. 13). Finally, it held that the challenge to the application of the ASTC Act and regulations to first trimester abortions was not moot. It found that those requirements were no longer applied to the occasional abortion provider, but that such requirements were applied to doctors who exclusively perform first trimester abortions. Further, the majority stated that the evidence on this point—testimony from the legal counsel for the state agency charged with enforcement authority that the challenged provision of the MPA was not being enforced—was ambiguous. (Jur. App. 13-14).

In considering the merits, the majority opinion, like the district court, relied upon the trimester approach of *Roe v. Wade*, 410 U.S. 113 (1973). (Jur. App. 15). It analyzed various decisions of this Court and stated that where first trimester abortions are involved, not only must the impact of the challenged regulations be insignificant in terms of the woman's exercise of her right, but also the regulation must be justified by important state health objectives. (Jur. App. 17).

The majority opinion concluded that the district court's application of a "medical necessity" standard was consonant with the applicable legal framework. (Jur. App. 18). Further, the majority rejected defendants' argument that regulations which apply to all facilities primarily devoted to surgery, should be reviewed under a different standard than those that singled out abortions. (Jur. App. 21). In addition, it decided that the district court's finding that

the challenged provisions substantially burden the effectuation of the abortion decision was not clearly erroneous. (Jur. App. 22).

The first facet of the challenged statutes and regulations which the majority considered was the requirement that facilities performing abortions be licensed at all. (Jur. App. 23). It held that under *Roe* the State may not require licensure of abortion facilities. (Jur. App. 24). Once the licensing requirement falls, the majority then reasoned that the remaining requirements fall with it. (Jur. App. 25). The majority also noted that many of the regulations, standing alone, seemingly would pass constitutional muster. (Jur. App. 25 n.11). Those include the pathology examination requirement, the general and abortion-specific reporting requirements, personnel and administrative requirements, operative and post-operative care regulations, and counselor qualification requirements. (Jur. App. 25-26 n.11).

Although the majority invalidated the entire statutory and regulatory framework with the licensure requirement, it considered and ruled upon the constitutionality of three abortion-specific regulations. First, it construed Section 205.730(a)(2) (Jur. App. 221) to unconstitutionally require the physician who is to perform the abortion to also perform a pregnancy test, even if such test had previously been done by another physician. (Jur. App. 27). Second, the majority held that Section 205.730(b)(3) (Jur. App. 221-22) invalidly requires counseling to include a discussion of alternatives, citing *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986). (Jur. App. 27). Third, it construed Section 205.730(b)(2)(D) (Jur. App. 221) to unconstitutionally preclude the performing physician from providing the counseling. (Jur. App. 28-29).

The generally applicable regulations regarding physical plant, equipment, and staffing were also struck down by the majority. It concluded that those provisions impose

a substantial burden and are not justified by health objectives. (Jur. App. 29-31).

In addition, the majority found the "certificate of need" requirement of the HFP Act unconstitutional. It held the State's interest in preventing wasteful duplication of resources to be insufficient in the abortion context. (Jur. App. 31-32).

Finally, the majority rejected defendants' request to sever those provisions which were held unconstitutional. It reasoned that severance was not appropriate because the licensure provision had been invalidated. (Jur. App. 32). Further, it found that the challenged provisions were "so riddled with exceptions resulting from judicial decisions and nonenforcement policies as to be unintelligible." The majority found, therefore, that it could not untangle the constitutional from the unconstitutional provisions. (Jur. App. 32-33).

The dissenting opinion found that the States are authorized under *Roe* to apply the same licensing standards to abortion facilities as those applied to facilities performing similar surgical procedures. (Jur. App. 35). Under that standard, the dissent would enjoin and sever the challenged portion of the Medical Practice Act and the abortion-specific language of par. 157-8.3(A) of the ASTC Act. (Jur. App. 38). The dissent argued that the States are free to regulate ambulatory surgical treatment centers, including those performing abortions, as long as abortions are not singled out from other similar surgical procedures, subject to the rational basis test governing social and economic legislation. Under the rational basis test, moreover, the dissent found the ASTC Act and HFP Act constitutional. (Jur. App. 64). In evaluating the abortion-specific statutes and regulations under the strict scrutiny test, the dissent would have upheld all provisions but one (Section 205.730(b)(2)(D)) (Jur. App. 73). The dissent found

that the challenged provisions neither burden the abortion decision nor its effectuation, and are justified by important health objectives. (Jur. App. 80).

SUMMARY OF ARGUMENT

In Illinois, minor surgical procedures are performed in doctors' offices, clinics, outpatient surgical facilities, and hospitals. In this case, the Court of Appeals struck the Illinois licensure and regulatory requirements for outpatient surgical facilities as applied to abortions. In so doing, the court improperly exempted abortions from general health and safety standards which were solely enacted in order to further the State's interest in protecting its citizens.

It is the State's position that its licensure and regulatory requirements do not impact the abortion decision, do not limit the availability of abortions, and are consistent with generally accepted medical, safety and construction standards. The defendants have not argued, and do not argue now, that *Roe v. Wade*, 410 U.S. 113 (1973) should be modified or overturned. Rather, the defendants maintain that these general health regulations do not conflict with or run afoul of the pronouncements of this Court in *Roe* and subsequent decisions. Indeed, those cases support the application of general health requirements to surgical facilities in which abortions are performed in the same manner they are applied to surgical facilities in which nonabortion surgical procedures are performed.

1. The Court of Appeals for the Seventh Circuit held unconstitutional and invalidated the Illinois laws as applied to first and early second trimester abortions. This Court

should, therefore, find that it has jurisdiction of this appeal pursuant to 28 U.S.C. Section 1254(2).

2. This Court should review the challenged abortion-neutral statutes and regulations under the rational basis test. Pursuant to that standard of review, the abortion-neutral provisions are constitutional because they are rationally related to legitimate and substantial state interests. Thus, this Court should uphold the authority of the State of Illinois to license and regulate outpatient surgical facilities in which pregnancy terminations are performed to the same extent that it licenses and regulates outpatient surgical facilities in which other minor surgical procedures are performed.

3. This Court should find that the challenged standards for the construction, maintenance and operation of outpatient surgical facilities are constitutional as applied to facilities in which first and early second trimester abortions are performed. The challenged provisions, as enforced by the State of Illinois, do not unduly burden the abortion decision. Because pregnancy terminations can be performed in doctors' offices, clinics, outpatient surgical facilities, and hospitals, the challenged statutes and regulations do not restrict the timing or availability of abortions. Further, the purported cost increases relating to compliance with the challenged provisions are *de minimis*.

4. The challenge to the abortion-specific provisions, which were not being enforced by the State of Illinois prior to the filing of the complaint, should have been dismissed. With respect to those provisions, jurisdiction is lacking under "case or controversy" requirements and under the Eleventh Amendment.

5. The lower courts should have scrutinized the challenged statutes and regulations separately and on their own merit. Any requirements found to be unconstitutional should have been severed.

ARGUMENT

A.

THIS COURT HAS APPELLATE JURISDICTION TO REVIEW THE FINAL JUDGMENT OF THE COURT OF APPEALS.

The final judgment of the Court of Appeals held unconstitutional and invalidated the challenged statutory and regulatory provisions as applied to persons or facilities performing or offering to perform first and early second trimester abortions or abortion-related gynecological procedures. This Court has appellate jurisdiction under 28 U.S.C. Section 1254(2).

In arguing that the judgment of the Seventh Circuit is not final and that this appeal is premature, the plaintiffs' Motion to Dismiss or Affirm focused upon comments of plaintiffs' counsel and the District Court made during the trial before the district court. (Pls.' Motion to Dismiss or Affirm, p. 6). It is clear from the record, however, that subsequent to certification of the classes and issuance of the district court decision, plaintiffs' counsel and the District Court did not anticipate further evidentiary proceedings. At that time, plaintiffs' counsel informed the District Court that given the scope of the evidentiary hearing, the briefing, and the scope of the court's order, plaintiffs were of the opinion that there was no need for further trial proceedings. (J.A. 68-69). The district court judge concurred, stating:

> THE COURT: . . . I can't really think of anything more that either side would put in that would really make all that much difference in the Seventh Circuit's decision in the case. It is really—the guts of the argument on both sides are in and the evidence is in. It is really a question of interpreting the Supreme Court decisions and maybe drawing a few reasonable infer-

ences. But there really isn't all that much in the way of factual disputes, it is really more a question of interpretation of the existing laws.

MR. GILBERT: Yes. Right. That's how we see it . . . (J.A. 70).

The plaintiffs have also attempted to argue that the Seventh Circuit merely affirmed a preliminary injunction order. It is clear, however, that in addition to affirming the preliminary injunction decision, the Seventh Circuit declared unconstitutional the licensure requirement and struck the other challenged provisions as applied to first and early second trimester abortions.

The district court judge who decided this case, moreover, recently had occasion to examine the scope of the Court of Appeals decision. In *Hedd Surgi-Center v. Turnock*, 711 F. Supp. 439 (N.D. Ill. 1989), *appeal docketed*, No. 89-1977 (7th Cir. May 10, 1989), a licensed ASTC which offers abortion and nonabortion surgical procedures, sought to enjoin the Illinois Department of Public Health from enforcing the ASTC Act as to any portion of the facility's practice (including nonabortion procedures). Hedd Surgi-Center argued that the Seventh Circuit had invalidated the ASTC Act in its entirety—even as to nonabortion surgical procedures. *Id.* at 439.

District Court Judge John Nordberg found that the Seventh Circuit had "invalidated" and "struck down" the Illinois legislation as it applied to first and early second trimester abortion procedures. *Hedd Surgi-Center, Inc. v. Turnock*, 711 F. Supp. at 443-44. Because the *Ragsdale* plaintiffs had not challenged the legislation as to nonabortion procedures, and the courts had not addressed that issue, Judge Nordberg denied the *Hedd* plaintiffs' motion for preliminary injunction. Defendants maintain that the Seventh Circuit's decision is a final declaratory judgment with respect to the challenged statutes and regulations in the abortion context.

This Court addressed the appellate finality issue in *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986). In that case, this Court concluded that it had no appellate jurisdiction under Section 1254(2) because the Third Circuit had not held the entire Act unconstitutional, had invalidated only some provisions, and had remanded the case for further development of the facts. *Id.* at 754-55.

In this case, however, the Seventh Circuit held all of the challenged statutes and regulations unconstitutional, and struck them as applied to first and early second trimester abortions. *See e.g., City of New Orleans v. Dukes*, 427 U.S. 297, 301-02 (1976) (where ordinance was found unconstitutional as applied and case was remanded for a determination of state-law question, finality requirement is met and the policy underlying Section 1254(2)—ensuring that state laws are not erroneously invalidated—would not be served by delaying adjudication of the constitutional issue). The Seventh Circuit did not remand for further development of facts. Rather, the Seventh Circuit's judgment is final and this Court has appellate jurisdiction under 28 U.S.C. Section 1254(2).

B.

THE LOWER COURT LACKED JURISDICTION TO HEAR THE CHALLENGE TO THE PROVISIONS WHICH WERE NOT ENFORCED.

Most of the challenged statutory and regulatory provisions are abortion-neutral and apply to all licensed ASTCs regardless of the type of surgical procedures which are performed. There are a few abortion-specific provisions. Because of judicial decisions pre-dating plaintiff's complaint, however, the State agencies charged with enforcement of the statutes and regulations decided not to enforce certain of the abortion-specific provisions. The evi-

dence of the State's nonenforcement policies was uncontradicted, and the Departments' policies of nonenforcement remain unchanged. The Court of Appeals, however, with one exception refused to give credence to that evidence, and considered and struck the unenforced provisions.

In light of the policies of nonenforcement which were articulated by the regulatory agencies and entered into evidence, plaintiffs did not present a justiciable controversy with respect to these unenforced provisions. The majority opinion, however, engaged in a mootness analysis of these provisions. They concluded that the challenge to the second trimester hospitalization requirement (ASTC regulation 205.740) (Jur. App. 222) was moot and should have been dismissed. (Jur. App. 13).

Nevertheless, the majority held, with respect to the reporting requirement of ASTC regulation 205.760 (Jur. App. 223), that the State's position of nonenforcement is "asserted only in this litigation" (Jur. App. 13). This conclusion is clearly erroneous. The evidence reveals that this regulation has not been enforced since 1983. (J.A. 242-43).

Similarly, the majority held, with respect to par. 4400-22 of the MPA (Jur. App. 193), that the evidence of nonenforcement was "equivocal". (Jur. App. 14). This conclusion is also clearly erroneous. Legal counsel to the Illinois Department of Registration and Education (now Department of Professional Regulation) testified that, based upon various court decisions in the abortion area, this section was not enforced. (J.A. 272-74).

Finally, the majority refused to dismiss the challenge to the abortion-specific language of par. 157-8.3 of the ASTC Act (Jur. App. 149-50), but acknowledged that "the requirement is apparently no longer applied to the 'occasional' abortion provider. . . ." (Jur. App. 14). The evidence reveals that this provision has not been enforced since 1981. (J.A. 48, 241-42, 267-69).

The mootness analysis was inappropriately applied by the majority. Mootness issues arise when a challenged policy or conduct ceases after the commencement of litigation. Here, the policies of nonenforcement were based on judicial decisions and regulatory determinations which predated the lawsuit. It is axiomatic that a court should look to the state of affairs as of the filing of the complaint in determining whether a justiciable controversy exists. *International Harvester Co. v. Deere & Co.*, 623 F.2d 1207, 1210 (7th Cir. 1980). No justiciable controversy exists, however, where there is an agreement not to enforce a challenged state law. *Congress of Industrial Organizations v. McAdory*, 325 U.S. 472, 475 (1945).

The decision in *Webster v. Reproductive Health Services*, 109 S. Ct. 3040 (1989) is instructive on this issue. In *Webster*, this Court refused to pass on the constitutionality of a section of the challenged Missouri legislation because it had not been applied to restrict the plaintiffs' activities in some concrete way. *Id.* at 3050.

Similarly, in this case the unenforced provisions have not been applied or threatened to be applied to plaintiffs' activities. Thus, plaintiffs lacked standing to challenge those statutes and regulations. *Poe v. Ullman*, 367 U.S. 497, 507 (1961) (lack of justiciable controversy found in challenge to unenforced prohibition against providing contraceptive advice and use of contraceptive devices).

The testimony of plaintiff Margaret Moe illustrates the standing problems. While Ms. Moe alleges in the complaint that the challenged legislation was preventing her from offering abortion services at her clinic, her testimony proved that was not the case. (J.A. 20-21). Ms. Moe, a nurse, testified that when she telephoned the Illinois Department of Public Health she was told that abortions could be performed at her health clinic without meeting any licensure requirements. (J.A. 267-69). Ms. Moe desired

to operate a health clinic, and not an outpatient surgical facility. Thus, her clinic was not required to be licensed as an ASTC.

In addition, the majority's refusal to dismiss the challenge to the unenforced statutes and regulation conflicts with the jurisdictional bar created by the Eleventh Amendment. That amendment limits the power of federal courts to grant relief where there are no ongoing violations of federal law. *Green v. Mansour*, 474 U.S. 64, 71 (1985). It bars further proceedings in federal court where there is no continuing conduct the State must alter to comply with federal law. *Watkins v. Blinzinger*, 789 F.2d 474, 484 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987). Because there was no ongoing violation of federal law, the lower court erred in assuming jurisdiction over the unenforced statutes and regulation.

C.

THE CHALLENGED PROVISIONS DO NOT VIOLATE THE CONSTITUTIONAL RIGHT TO PRIVACY.

The defendants are not asking this Court to reconsider or overturn its decision in *Roe v. Wade*, 410 U.S. 113 (1973). Rather, the defendants maintain that the Court of Appeals misapplied the standards enunciated in *Roe* and its progeny, and that the challenged statutes and regulations withstand constitutional scrutiny.

Stripped of the challenges to the abortion-specific language of par. 157-8.3 of the ASTC Act (Jur. App. 149-50) and par. 4400-22 of the MPA (Jur. App. 193), this case turns on whether the State of Illinois is authorized to license and regulate outpatient surgical facilities in which first and early second trimester abortions are performed to the same extent that it regulates all other outpatient surgical facilities. The majority opinion, however, struck the ASTC Act's licensure requirement as applied to abortions as well as the HFP Act provisions. (Jur. App. 24, 31). In so doing, the majority improperly applied a strict scrutiny test to these requirements notwithstanding their general, abortion-neutral applicability.

Defendants maintain that the abortion-neutral statutes and regulations should be reviewed under the rational basis test. Pursuant to that standard of review, these provisions are constitutional because they are rationally related to legitimate and substantial state interests.

In the alternative, defendants maintain that these challenged provisions are not unconstitutional under strict scrutiny standards because they do not unduly burden the abortion decision. Thus, this Court should find that the standards for licensure, construction, maintenance and operation of outpatient surgical facilities are constitutional as applied to those facilities in which first and early second trimester abortions are performed.

1. **The Abortion-Neutral Statutes And Regulations Should Be Upheld Under The Rational Basis Test.**

It is well established that state laws which do not impinge on a suspect class or fundamental rights are presumptively valid and should be upheld unless the laws rest on grounds wholly irrelevant to any legitimate governmental objective. *Harris v. McRae*, 448 U.S. 297, 322 (1980). Such laws are constitutional so long as a conceivable rational basis exists for their requirements. *Williamson v. Lee Optical Co.*, 348 U.S. 483, 488 (1955).

It is equally well established that the State of Illinois has broad power to promulgate and enforce health standards within its borders as part of its police power. *Barsky v. Board of Regents*, 347 U.S. 442, 449 (1954). The regulation of the practice of medicine is clearly within the State's authority. *Id.* at 451. Moreover, the regulation of

doctors has never been "the business of judges." *Parham v. J.R.*, 442 U.S. 584, 608 (1979).

This Court has consistently held, even with respect to first trimester abortions, that the State has an interest in making sure that certain factual assumptions made in *Roe v. Wade*, 410 U.S. 113 (1973) continue to exist. As explained in *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 430 n.12 (1983):

> Of course, the State retains an interest in ensuring the validity of Roe's factual assumption that "the first trimester abortion [is] as safe for the woman as normal childbirth at term," an assumption that "holds true only if the abortion is performed by medically competent personnel under conditions insuring maximum safety for the woman." *Connecticut v. Menillo*, 423 U.S. 9, 11, 46 L.Ed.2d 152, 96 S.Ct. 170 (1975) (per curiam).

The ASCT Act seeks to effectuate that interest by "assuring that all medical procedures, including abortions, are performed under conditions that insure maximum safety." (Jur. App. 149). Similarly, the HFP Act seeks to "establish an orderly and comprehensive health care delivery system which will guarantee the availability of quality health care to the public." (Jur. App. 166).

The ASTC Act was enacted to further the State's interests in regulating the ever increasing number of outpatient surgical facilities. The Act's legislative history reveals that it was passed in 1973 at the urging of the Illinois State Medical Society in order to regulate same-day surgical facilities which perform minor surgery. The surgical procedures mentioned at that time were tonsillectomies, hernias, abortions and plastic surgery. The legislative debates further note that doctors had been urging such legislation for a couple of years, and that these facilities would provide a great cost savings to patients. (A. 18-19).

The State has the responsibility to its citizens to insure that medical procedures performed at these facilities are performed under circumstances enhancing their safety. Further, the State can legitimately seek to establish a comprehensive and less costly health care delivery system. These significant interests do not cease when an abortion is the surgical procedure which is to be performed. Because such laws are rationally related to legitimate government objectives, they should be sustained. *Harris v. McRae*, 447 U.S. 297, 325 (1980).

The Court of Appeals suggested that the State is irrationally attempting to regulate experienced physicians to the exclusion of the occasional abortion provider. (Jur. App. 24). However, the ASTC Act and the HFP Act regulate facilities—not physicians. The assumption that physicians who perform abortions in licensed facilities are more experienced and more responsible is one which the majority made without evidentiary support. Further, if a lay-operated facility has no medical director, the responsibility and liability for medical decisions may rest with individuals with no understanding or professional experience with those responsibilities. (J.A. 221).

In *Birth Control Centers, Inc. v. Reizen*, 743 F.2d 352 (6th Cir. 1984), the court recognized that in private offices the physician generally has direct control over staff and office functions. In outpatient surgical facilities, however, nonphysicians may have control over personnel, equipment and design of the facility. The Sixth Circuit concluded, therefore, that it was not unreasonable for Michigan to decide to regulate free-standing surgical facilities including abortion clinics while not regulating physicians' offices. *Id.* at 358-59.

The statutes and regulations which were invalidated in this case reflect a similar reasonable decision by the State of Illinois. Likewise, the State can rationally utilize its

limited resources to regulate those facilities which have made it their business to perform surgical procedures, and are thus more in need of scrutiny as to appropriate staff, equipment and record keeping.[7]

The argument that abortion-neutral regulations should not be reviewed under a strict scrutiny standard is also supported by decisions of this Court in other contexts. For example, content-neutral restrictions on time, place, or manner of protected free speech are not scrutinized under the compelling interest test. Rather, content-neutral speech regulations are valid if narrowly tailored to serve a significant government interest and if ample alternative channels for communication of information are left open. *Ward v. Rock Against Racism*, 109 S. Ct. 2746. 2753 (1989) (upholding regulation requiring certain music performers to use sound-amplification equipment and a sound

[7] Several lower courts have upheld the application of surgical center standards to facilities performing abortions. *Baird v. Department of Public Health*, 599 F.2d 1098, 1102 (1st Cir. 1979) ("There is room under *Roe* for states to apply the same licensing standards to abortion facilities as they apply to like facilities performing medically analogous procedures."); *Hodgson v. Lawson*, 542 F.2d 1350, 1358 (8th Cir. 1976) ("A state can impose the same regulations on a clinic, specifically built to perform abortions during the first trimester, that are imposed on other clinics that perform surgical procedures requiring approximately the same degree of skill and care as the performance of first trimester abortions."); *Westchester Women's Health Org. v. Whalen*, 475 F. Supp. 734 (S.D.N.Y. 1979) (requirements governing "diagnostic and treatment centers" applicable to facilities performing first trimester abortions); *Abortion Coalition of Mich. Inc. v. Mich. Dep't of Public Health*, 426 F. Supp. 471 (E.D. Mich. 1977) (requirements for "free standing surgical outpatient facilities" applicable to facilities performing first trimester abortions). In contrast, where abortion clinics are singled out for regulation, the requirements have been struck down. *Mahoning Women's Center v. Hunter*, 610 F.2d 456 (6th Cir. 1979), *vacated on other grounds*, 447 U.S. 918 (1980); *Friendship Medical Center, Ltd. v. Chicago Board of Health*, 505 F.2d 1141 (7th Cir. 1974), *cert. denied*, 420 U.S. 997 (1975); and *Word v. Poelker*, 495 F.2d 1349 (8th Cir. 1974).

technician provided by a municipality). Thus, this Court has sustained a zoning ordinance prohibiting adult motion picture theatres from locating near residences, churches, parks, and schools. *City of Renton v. Playtime Theatres, Inc.*, 475 U.S. 41, 48 (1986).

In addition, "neither the press, nor booksellers may claim special protection from governmental regulations of general applicability simply by virtue of their First Amendment protected activities." *Arcara v. Cloud Books, Inc.*, 478 U.S. 697, 705 (1986) (sustaining closure of adult bookstore used as place of prostitution against free speech challenge). Similarly, plaintiffs should not be entitled to an exemption from the abortion-neutral provisions. Those provisions should be upheld as rationally related to significant government objectives.

At the time of trial, there were 42 licensed ASTCs in Illinois. Abortions were performed at 22 of those facilities. (J.A. 241). The lower court decisions have created a regulatory quagmire for the State's licensing agencies. Those decisions have completely exempted from regulation surgical facilities which exclusively perform abortions, while facilities which offer abortion and nonabortion surgical procedures are exempt as to abortions.[8]

This situation is untenable. The State has as much of an interest in ensuring the safety of patients seeking abortions at these facilities as it has in ensuring the safety of patients desiring nonabortion surgical procedures. By

[8] The plaintiff facility in *Hedd Surgi-Center, Inc. v. Turnock*, 711 F. Supp. 439 (N.D. Ill. 1989), *appeal docketed*, No. 89-1977 (7th Cir. May 10, 1989) typifies this situation. That facility has alleged that 90% of its surgical practice is abortions. *Id.* at 441. Thus, the Department of Public Health is limited to regulating the facility only as to its 10% nonabortion surgery practice. In order to completely escape regulation, the facility need only eliminate its 10% nonabortion services.

exempting abortions from these general regulations, the lower court has erroneously fostered a situation which may encourage unethical and unqualified individuals to operate substandard, unregulated surgical facilities specializing in abortions.

2. The Challenged Provisions Do Not Unduly Burden The Abortion Decision.

Assuming, *arguendo*, that the generally applicable statutes and regulations were appropriately reviewed under the strict scrutiny test, the Court of Appeals erred in determining that those provisions unduly burden the abortion decision. The constitutional right to privacy does not completely void every State regulation which touches upon an individual's protected liberty interests. *Carey v. Population Services International*, 431 U.S. 678, 685-86 (1977). Rather, an abortion requirement is not unconstitutional unless it unduly burdens the right to seek an abortion. *Maher v. Roe*, 432 U.S. 464, 473-74 (1977).

Much of the evidence submitted by plaintiffs revolved around a theory that only "medically necessary" laws or regulations may be applied to a physician or facility performing first or early second trimester abortions. This approach misstates the standard for reviewing abortion regulations; only unduly burdensome requirements are constitutionally suspect.

a. Regulations Based Upon Generally Accepted Standards Do Not Interfere With the Abortion Decision.

The evidence at trial revealed that many of the challenged provisions are consistent with generally accepted medical standards. For example, various sections of the regulations require that ASTCs formulate a written policies and procedures manual and written safety plans (Sections

205.240 and 205.510) (Jur. App. 213, 216); that complete medical history be taken and a complete physical examination be given prior to the surgical procedure (Section 205.520(b)) (Jur. App. 216-17); that ambulatory care facilities for abortion services meet the same standards of care as for other surgical procedures (Section 205.710) (Jur. App. 220); that counseling be provided prior to obstetrical/gynecological procedures (Section 205.730(b)) (Jur. App. 221); that patients who have had certain procedures performed be observed to ensure that no postoperative complications are present (Section 205.540(a)) (Jur. App. 21[illegible]); that routine laboratory work be performed (Section 205.730) (Jur. App. 221-22); and that tissue removed during surgery be examined by a consulting pathologist (Section 205.530(c)) (Jur. App. 217).[9]

Further, the evidence reflects that other provisions meet generally accepted design, construction, mechanical, fire and building requirements. For example, various sections of the regulations require that the building heating and air systems are to be tested to ensure proper working condition (Section 205.1510) (Jur. App. 240); that insulation meet national fire safety requirements (Section 205.1520) (Jur. App. 240-41); that air systems meet certain filter efficiencies (Section 205.1540(h)) (Jur. App. 243); that examining rooms be equipped with handwashing facilities (Section 205.1360(a)(2)) (Jur. App. 231); and that ceiling heights meet universal minimums. (Section 205.1400(n)) (Jur. App. 237). These requirements comport with common, accepted

[9] The requirement that all tissue removed during surgery be examined by a pathologist is applicable to all surgical procedures. It has, moreover, been held to be constitutional in the abortion context. *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476, 486-90 (1983).

and standard practices. (J.A. 57-59, 226-29, R. 739-40; Def. Ex. 9, Linder Dep. 76-77, R. 782).[10]

Requiring an outpatient surgical center to comply with accepted medical, safety and sanitation requirements does not interfere with the decision to terminate a pregnancy. Abortions are surgical procedures which should be treated with the same respect as other similar surgical procedures. (J.A. 285). In fact, plaintiffs' expert witness testified that few surgical procedures are as underrated in their potential for hazard as abortions. (J.A. 218). Exempting abortions from the health and safety regulations applied to other minor surgical procedures is contrary to the best interests of women who may seek to have abortions at outpatient surgical facilities.

In addition, the finding that the regulations require ASTCs to be "the functional equivalent of small hospitals" (Jur. App. 19), simply misses the mark. The evidence of record establishes that there is a basis of comparison between some of the construction regulations and hospital regulations. However, it is clear that the ASTC regulations are, overall, less stringent than hospital regulations. (R. 739, 749-50; Def. Ex. 9, Linder Dep. 53-56). Significantly, the ACOG standards provide that ambulatory surgical facilities should maintain the same surgical, anesthetic, and personnel standards that hospitals do. (J.A. 52). Indeed, this Court has noted the apparent need to impose stringent health and safety standards on outpatient surgical centers performing abortions as are recommended for hospitals. *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476, 488 (1983); *Simopoulous v. Virginia*, 462 U.S. 506,

[10] Other regulations meeting generally accepted standards are detailed in the Statement of the Case, *ante* at 13-21. In addition, the majority opinion noted that many of regulations, standing alone, seemingly would pass constitutional muster. (Jur. App. 25-26 n.11).

517 (1983). The Illinois standards for patient care, personnel, management, design and operation of ASTCs do not interfere with the abortion decision. Those standards should be required at surgical facilities because they comport with generally accepted medical and building design practices.

b. The Estimated Cost Of Compliance With The Regulations Is *De Minimus*.

The purported cost increase relating to compliance with the challenged provisions is *de minimis*. A cost analysis is contained in Plaintiffs' Exhibits 17 and 18. (J.A. 35). These handwritten documents were prepared by Dr. Ragsdale and represent his rough guess of cost increases. (J.A. 138, 140). Exhibit 17 represents costs of relocating Dr. Ragsdale's facility and without regard to the State's requirements. (J.A. 141-43). Plaintiffs' Exhibit 18 represents cost estimates, in addition to those delineated in Exhibit 17, which Dr. Ragsdale believed would enable him to bring the proposed facility into "reasonable compliance" with the ASTC regulations. (J.A. 144-45).[11]

[11] The estimates contained in plaintiffs' Exhibits 17 and 18 are based upon Dr. Ragsdale's conversations with various individuals: architects, contractors, plumbers, heating people and other vendors. (J.A. 141, 156). Defendants objected to the admission of those two documents on hearsay grounds. The majority opinion, however, incorrectly found that Dr. Ragsdale was permitted to testify as to the substance of his handwritten cost estimates, without objection (Jur. App. 22 n.10). As correctly stated in the dissenting opinion, "the defendants objected throughout the hearing as to the relevancy and admissibility of Ragsdale's alleged cost sheets" (Jur. App. at 67). At the outset, defendants objected to any use of those documents (J.A. 139). Further objections were raised when plaintiffs moved for their admission into evidence (J.A. 162-63). Plaintiffs' Exhibits 17 and 18 fall squarely within the prohibition against the admission of hearsay evidence.

Dr. Ragsdale testified that the expenses needed to be incurred in order to attain reasonable compliance with the ASTC regulations would result in raising his fee an estimated $25.21 per patient. (J.A. 146). Using plaintiffs' financial model, however, a remodeling expense debt would have been retired after two years. (J.A. 159). Further, the debt incurred for installation of an elevator to provide access to disabled individuals would have been retired after five years. (Plaintiffs' Ex. 18; J.A. 35). Thus, after two years the fee increase would be reduced to $10.90 per patient and after five years the fee increase would be reduced to $3.40 per patient. This increase is *de minimis* and did not sustain plaintiffs' burden of proof even under the standards found applicable by the majority. (Jur. App. 23). *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476, 490 (1983) (estimated cost of $19.40 for a State required pathology report did not "significantly burden a pregnant woman's abortion decision.")[12]

c. Neither The Timing Nor The Availability Of Abortions Is Unduly Restricted.

The challenged provisions, as enforced by the State, do not unduly restrict the timing or availability of abortions. Pregnancy terminations can be performed in doctors' offices, clinics, outpatient surgical facilities and hospitals. In fact, plaintiff Moe testified that she knew of at least two physicians in Illinois who have been performing abortions in their offices. (J.A. 271).

In *Webster v. Reproductive Health Services*, 109 S. Ct. 3040, 3053 (1989), this Court upheld State restrictions on the use of public employees and facilities for the performance or assistance of nontherapeutic abortions. It was determined that the "challenged provisions only restrict a woman's ability to obtain an abortion to the extent that she chooses to use a physician affiliated with a public hospital." *Id.* at 3052. Similarly, the statutes and regulations at issue in this case only restrict the abortion decision to the extent that the woman chooses a doctor associated with an outpatient surgical facility. Because of the availability of alternatives (*i.e.* offices, clinics and hospitals) the challenged statutes and regulations do not unduly burden the abortion decision.

[12] *Cf. Birth Control Centers, Inc. v. Reizen*, 743 F.2d 352, 365 (6th Cir. 1984) (regulations for freestanding surgical outpatient facilities struck down where compliance would increase weekly operating expenses by 54% to 156%).

3. The Court Of Appeals Erroneously Struck Down Three Abortion-Specific Regulations.

After striking down the licensure requirement, the majority opinion considered and declared unconstitutional three abortion-specific regulations which were not specifically challenged below. First, it construed Section 205.730(a)(2) (Jur. App. 221) to unconstitutionally require the physician who is to perform the abortion to also perform a pregnancy test, even if such test had previously been done by another physician. (Jur. App. 27). This construction is clearly erroneous.

This regulation merely provides that the physician performing the abortion establish "the diagnosis of pregnancy . . . prior to performing the procedure". In other words, the physician must ensure that there has been an appropriate evaluation completed and a diagnosis of pregnancy made. It does not require a second pregnancy test, and the majority's speculation on this point is not supported by a fair reading of the regulation or by the record.

Second, the majority held that Section 205.730(b)(3) (Jur. App. 221-22) invalidly requires counseling to include a discussion of alternatives, citing *Thornburgh v. American*

College of Obstetricians and Gynecologists, 476 U.S. 747 (1986). (Jur. App. 27). This regulation requires counseling to include "a discussion of alternatives, description of the procedure to be performed, explanation of risks and possible complications." In stark contrast, the statute at issue in *Thornburgh* required "a litany of information" including a description of fetal characteristics, availability of financial assistance, detrimental physical and psychological effects, and all particular medical risks. *Id.* at 760-61.

The ASTC regulation is merely a restatement of the physician's common law duty to reasonably disclose the choices relating to the proposed procedure and the dangers inherently and potentially involved. *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972). According to plaintiffs' expert witness, moreover, counseling is an indispensable part of a thorough preoperative evaluation and preparation of a patient for an abortion procedure. (J.A. 218). Further, plaintiffs' expert and the ACOG standards agree that counseling should include a discussion of the alternatives for dealing with pregnancy. (J.A. 55, 210-11). Because this regulation is designed to ensure the patient's informed consent, it should be upheld. *Planned Parenthood v. Danforth*, 428 U.S. 52, 66-67 (1976).

Third, the majority construed Section 205.730(b)(2)(D) (Jur. App. 221) to unconstitutionally preclude the performing physician from providing the counseling. (Jur. App. 28-29). The majority's reading of this regulation runs afoul of the well-established principle that courts should construe laws to avoid constitutional infirmities. *Frisby v. Schultz*, 108 S. Ct. 2495, 2501 (1988). The regulation provides that "[c]ounselors shall have no financial interest in the patient's decision." The regulation is directed at nonphysician counselors and is intended to preclude arrangements whereby counselors receive compensation only if

the patient has an abortion at the facility. Such financial arrangements are improper, and do not further the patient's interest in making an informed choice.

The majority, on the other hand, misconstrued the regulation so as to cause a constitutional confrontation. In addition, this construction was arrived at without the benefit of any evidence whatsoever as to the administrative interpretation and implementation of this regulation or input from the enforcement agency. Such a failure to consider the possibility of a limiting construction is improper. *Ward v. Rock Against Racism*, 109 S. Ct. 2746, 2756 (1989). Thus, the majority's declaration of invalidity should be rejected.

D.

THE COURT OF APPEALS ERRONEOUSLY REFUSED TO SEVER ANY PROVISIONS IT FOUND UNCONSTITUTIONAL.

Although the majority recognized that some of the ASTC regulations would pass constitutional muster, it refused to sever those which it found unconstitutional. In rejecting the State's severance arguments, the majority characterized the regulatory scheme as being "so riddled with exceptions resulting from judicial decisions and nonenforcement policies as to be unintelligible." (Jur. App. 33).

As this Court has noted, judges should refrain from invalidating more of a statute than is necessary. *Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984). It is, moreover, the duty of courts to "maintain the act in so far as it is valid." *Id.* at 652, quoting *El Paso & Northeastern R. Co. v. Gutierrez*, 215 U.S. 87, 96 (1909). Further, this Court has held that "[u]nless it is evident that the Legislature would not have enacted those provisions which are within

its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law." *Buckley v. Valeo*, 424 U.S. 1, 108-09 (1976), quoting *Champlin Refining Co. v. Corporation Commission*, 286 U.S. 210, 234 (1932).

Assuming, *arguendo*, that the lower court appropriately assumed jurisdiction over the challenged provisions which were not enforced, that court should have severed those provisions it found unconstitutional. For instance, the abortion-specific language of par. 157-8.3 of the ASTC Act has not been enforced since 1981 due to the decision of the Illinois Supreme Court in *Village of Oak Lawn v. Marcowitz*, 86 Ill. 2d 406, 427 N.E.2d 36 (1981). In that case, the Illinois court struck down and severed the abortion-specific language, but found the remaining portion of the ordinance to be "complete in itself and susceptible to independent enforcement." *Id.* at 421.

Given the ASTC Act's declared purpose of assuring that *all* medical procedures, including abortion, be performed under circumstances insuring maximum safety, the Supreme Court of Illinois' holding on severability in *Marcowitz*, and the State's policy of nonenforcement, there is no doubt that the abortion-specific language of the ASTC Act should have been severed if declared unconstitutional. Similarly, any purportedly unconstitutional provisions of the MPA, the HFP Act and the ASTC regulations should have been severed. By failing to appropriately address the severability issue, the majority opinion improperly frustrated the intent of the elected representatives of the people of the State of Illinois. *Regan v. Time, Inc.*, 468 U.S. at 653.

CONCLUSION

For these reasons, this Court should find that it has jurisdiction over this appeal, reverse the judgment of the Court of Appeals for the Seventh Circuit and vacate the injunction entered against the defendants.

Respectfully submitted,

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August 31, 1989

APPENDIX

APPENDIX A

77 Illinois Administrative Code, Chapter 1, § 205, Subchapter b

* * * * *

SUBPART A: GENERAL

Section 205.110 Definitions

"Ambulatory Surgical Treatment Center." The term ambulatory surgical treatment center shall have meaning as ascribed in the "Ambulatory Surgical Treatment Center Act" of 1973 as now and hereafter amended. (The Act) (Ill. Rev. Stat. 1979, ch. 111½, pars. 157-8.1 et seq.).

"Certified Registered Nurse Anesthetist" means a registered professional nurse who has been certified as a nurse anesthetist by the American Association of Nurse Anesthetists.

"DEPARTMENT" MEANS THE DEPARTMENT OF PUBLIC HEALTH OF THE STATE OF ILLINOIS.

"Licensed Practical Nurse" means a person licensed under The Illinois Nursing Act (Ill. Rev. Stat. 1979, ch. 111, par. 3401 et seq.) to practice practical nursing.

"Qualified Anesthesiologist" means a physician who is licensed to practice medicine in all its branches in the State of Illinois and who is a Diplomate of the American Board of Anesthesiology; or American College of Anesthesiology; or who is a Diplomate of the American Osteopathic Board of Anesthesiology; or who is Board eligible or possess training and experience equivalent to such eligibility; or who possess training and experience acceptable to the Department and whose primary practice is anesthesiology.

"Qualified Consulting Committee" means a committee whose members are qualified Surgeons, Obstetricians, Gynecologists, Anesthesiologists or Pathologists or other

Consulting Physicians consisting of not less than 3 members who shall establish the required standards commensurate with the size, scope, extent and complexity of service programs and procedures for which the facility is licensed. The consulting committee or other committee designated by the consulting committee shall act as the credentials committee.

"Qualified Consulting Surgeon, Obstetrician, Gynecologist, Anesthesiologist, Pathologist, or other Consulting Physician" means a physician who is licensed in the State of Illinois and who is a Diplomate of an appropriate specialty board or who has completed the training and experience required for specialty board certification.

"Qualified Physician" means an individual who is licensed to practice medicine in all branches in the State of Illinois.

"Qualified Dentist" means a dentist who is licensed to practice under the Dental Practice Act, (Ill. Rev. Stat. 1979, ch. 111, pars. 2202 et seq.).

"Qualified Podiatrist" means a podiatrist who is licensed to practice under "An Act to regulate the practice of podiatry in the State of Illinois", (Ill. Rev. Stat. 1979, ch. 111, pars. 4901 et seq.).

"Registered Professional Nurse" means a registered nurse or a registered professional nurse who is registered under the Illinois Nursing Act (Ill. Rev. Stat. 1979, ch. 111, pars. 3401 et seq.), and practices professional nursing.

"Student Nurse" means a person enrolled in a course of instruction at an approved school of professional or practical nursing and who is supervised by a nursing instructor of the school.

(Source: Amended at 9 Ill. Reg. 12014, effective July 23, 1985)

Section 205.115 Incorporated and Referenced Materials

a) The following regulations, standards, and statutes are incorporated or referenced in this Part:
   1) Private and professional association standards:

A) American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE), Standard No. 52-68: Methods of Testing Air Cleaning Devices Used in General Ventilation for Removing Particulate Matter (1968) [See Section 205.1540(i)] and Handbook of Fundamentals (1981) [See Section 205.1540(p)], which may be obtained from the National Association of American Society of Heating, Refrigerating, and Air Conditioning, United Engineering Center, 345 East 47th Street, New York, New York 10017.

B) National Fire Protection Association (NFPA), Chapter 12, Section 12-6 (New Ambulatory Health Care Centers), and Chapter 26 (New Business Occupancies) of Standard No. 101: Life Safety Code (1981) [See Section 205.1400(a)] and the following standards, which may be obtained from the National Fire Protection Association, Batterymarch Park, Massachusetts 02269.
   i) No. 56A (1978): Inhalation Anesthetics. [See Section 205.410]
   ii) No. 70 (1984): National Electrical Code. [See Sections 205.1760, 205.1770 and 205.1780]
   iii) No. 80 (1981): Standard for Fire Doors and Windows. [See Section 205.1400(f)]
   iv) No. 90A (1978): Installation of Air Conditioning and Ventilating Systems. [See Section 205.1540]
   v) No. 90B (1980): Installation of Warm Air Heating and Air Conditioning Systems. [See Section 205.1540]
   vi) No. 255 (1979): Method of Test of Surface Burning Characteristics of Building Materials. [See Sections 205.1410 and 205.1520]

vii) No. 701 (1977): Standard Methods of Fire Tests for Flame-Resistant Textiles and Films. [See Section 205.1400(j)]

C) American Hospital Association, "Infection Control in the Hospital" (1979), which may be obtained from the American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60601. [See Section 205.410]

D) National Council on Radiation Protection (NCRP), Report No. 33: Medical X-ray and Gamma Ray Protection for Energies up to 10MeV Equipment Design and Use (1968), and Report No. 49: Medical X-ray and Gamma Ray Protection for Energies up to 10 MeV Structural Shielding Design and Evaluation (1976), which may be obtained from the National Council on Radiation Protection and Measurement, P.O. Box 30175, Washington, D.C. 20014. [See Section 205.1400(g)]

E) Underwriters Laboratories, Inc. (UL), Publication No. 181 (1974): Air Ducts; which may be obtained from Underwriters Laboratories, Inc., 207 East Ohio Street, Chicago, Illinois 60611. [See Section 205.1710]

2) State of Illinois Statutes:

A) Ambulatory Surgical Treatment Center Act (Ill. Rev. Stat. 1985, ch. 111½, par. 157-8.1 et seq.)

B) Illinois Dental Practice Act (Ill. Rev. Stat. 1985, ch. 111, par. 2301 et seq.)

C) Illinois Nursing Act (Ill. Rev. Stat. 1985, ch. 111, par. 3401 et seq.)

D) "AN ACT to regulate the practice of podiatry in Illinois" (Ill. Rev. Stat. 1985, ch. 111, par. 4901 et seq.)

E) Safety Glazing Materials Act (Ill. Rev. Stat. 1985, ch. 111½, pars. 3101 et seq.)

3) State of Illinois Rules:

A) Department of Public Health, Illinois Plumbing Code (77 Ill. Adm. Code 890)

B) Department of Nuclear Safety, Radiation Protection (32 Ill. Adm. Code: Chapter I, Subchapter b)

b) All incorporations by reference of federal regulations and the standards of nationally recognized organizations in this Part refer to the regulations or standards on the date specified and do not include any additions or deletions subsequent to the date specified.

(Source: Added at 12 Ill. Reg. 3743, effective February 15, 1988)

Section 205.230 Standards of Professional Work

Management and/or the owner of the ambulatory surgical treatment center shall maintain proper standards of professional work in the licensed facility.

a) A qualified consulting committee shall be appointed in writing by the management and/or owner of the ambulatory surgical treatment center and shall establish and enforce standards for professional work in the facility and standards of competency for physicians. The consulting committee shall meet not less than quarterly and shall document all meetings with written minutes. These written minutes shall be maintained at the facility and shall be available for inspection by the Department.

1) The membership of the consulting committee shall reflect the types of procedures performed. If the facility performs more than 50 procedures per month or more than 10% of the total procedures performed are in a specific speciality area then there shall be a consulting physician of that specialty on the consulting committee.

2) The consulting committee shall review development and content of the written policies and procedures of the center, the procedures for

granting privileges, and the quality of the surgical procedures performed. Evidence of such review shall be recorded in the minutes.

3) Credentials shall be provided by those physicians seeking practice privileges. These credentials shall be reviewed by the credentials committee and specific practice privileges identified and recorded. Record of such accepted practice privileges shall be available for facility staff use and public information within the facility.

4) Each member of the medical staff granted specific surgical practice privileges shall provide a notarized statement or documentation indicating the name of the Illinois' licensed hospital(s) where they have skilled-equivalent practice privileges. Such statements or documentation shall be available for inspection by the Department. A list of privileges granted each medical staff member of the ambulatory surgical treatment center shall be available at all times for use by the staff of the center and for inspection by Department staff. As used in this subsection, "skilled-equivalent" means the ability to perform similar procedures requiring the same level of training and expertise.

5) The consulting committee shall act as a tissue committee and shall review at least quarterly pathological reports from procedures performed by each physician on the staff. Evidence of such review shall be recorded in the minutes.

b) A qualified physician shall be designated "Medical Director."

1) The Medical Director shall secure compliance with the policies and procedures pertaining to medical and surgical procedures, approved by the consulting committee.

2) The Medical Director shall be responsible for the implementation of medical policies and procedures contained in the facility's policies and procedures manual (Section 205.240) governing

the professional personnel involved directly in the care of patients undergoing surgical procedures, including their preoperative and postoperative care and follow-up.

3) The Medical Director shall establish and secure compliance of standards for the observation of patients by nursing personnel during the postoperative period.

(Source: Amended at 10 Ill. Reg. 21906, effective January 15, 1987)

Section 205.330 Nursing Personnel

a) At least one registered professional nurse with postgraduate education or experience in surgical nursing shall direct and supervise the nursing personnel and the nursing care of patients and shall be on duty at all times on the premises when patients are present.

b) Nursing care may be provided by student nurses and licensed practical nurses who have been trained in observation and emergency techniques for preoperative and postoperative care of surgical patients and who are under the direct personal supervision of a registered nurse at all times.

(Source: Amended at 12 Ill. Reg. 3743, effective February 15, 1988)

Section 205.420 Sanitary Facility

a) The ambulatory surgical treatment center shall insure maintenance of a sanitary facility with all equipment in good working order. Written procedures shall include provision for garbage and refuse removal, insect and rodent control, maintenance of water, heat, ventilation and air conditioning, and electrical service.

b) Any blood, blood components, organs, semen, or other human tissue showing exposure to human immunodeficiency virus (HIV) as evidenced by two of

three reactive ELISA test results (according to the package insert–product circular), or exposure to any other identified causative agent of Acquired Immunodeficiency Syndrome (AIDS), and any blood, blood components, organs, semen, or other human tissue originating from a patient diagnosed with AIDS or ARC as defined in 77 Ill. Adm. Code 693.20, shall be disposed of by the center in accordance with subsection (c) of this Section, or delivered in accordance with subsection (d) of this Section to a research facility to use such blood, blood components, organs, semen, or other human tissue for AIDS research.

c) Any such blood, blood components, organs, semen, or other human tissue, and any other materials or paraphenalia exposed to, or contaminated by, such blood, blood components, organs, semen, or other human tissue shall be completely incinerated, sterilized, or sealed in order to render the materials innocuous before disposal or removal from the premises.
   1) The incineration of materials shall be done in accordance with the requirements of the Pollution Control Board concerning the operation of an incinerator (35 Ill. Adm. Code 724).
   2) The sterilization of materials shall be done by autoclaving the materials in accordance with the recommendations of the manufacturer of the autoclave. The effectiveness of the autoclave shall be verified and documented at least weekly with a biological spore assay containing B. stearothermophilus.
   3) Incinerated or sterilized materials shall be disposed of through routine waste disposal methods.
   4) Materials which have not been incinerated or sterilized shall be disposed of by a waste hauler with a proper permit from the Illinois Environmental Protection Agency under rules of the Pollution Control Board (35 Ill. Adm. Code 809). These materials must be sealed, transported,

and stored in biohazard containers. These containers shall be marked "Biohazard," bear the universal biohazard symbol, and be orange, orange and black, or red. The containers shall be rigid and puncture-resistant such as a secondary metal or plastic can with a lid that can be opened by a step-on pedal. These containers shall be lined with one or two high density polyethylene or polypropylene plastic bags with a total thickness of at least 2.5 mil. or equivalent material. The containers shall be sealed before being removed from the facility.

d) When a center delivers such blood, blood components, organs, semen, or other human tissue to a research facility, the center shall file a report with the Department (Division of Laboratories) which shall include at least the following information:
   1) A copy of the request from the research facility for the blood, blood components, organs, semen, or other human tissue;
   2) The quantity of blood, blood components, organs, semen, or other human tissue delivered;
   3) The name and location of the research facility to which the blood or other human tissue was delivered; and
   4) The date and time of delivery.

e) A research facility, for the purposes of this Section, shall mean any clinical laboratory licensed under the Clinical Laboratory Act (Ill. Rev. Stat. 1987, ch. 111½, par. 621 et seq.), any blood bank licensed under the Illinois Blood Bank Act (Ill. Rev. Stat. 1987, ch. 111½, par. 601-101 et seq.) or any hospital licensed under the Hospital Licensing Act (Ill. Rev. Stat. 1987, ch. 111½, par. 142 et seq.)

(Source: Amended at 12 Ill. Reg. 15573, effective October 1, 1988)

Section 205.530 Operative Care

a) Surgical procedures shall be performed only by a qualified physician, dentist or podiatrist within the limits of his/her defined specific practice privileges.

b) A qualified anesthesiologist, a dental anesthesiologist or a certified registered nurse anesthetist, medically directed by a licensed physician who administers or directs the administration of anesthesia in an Illinois licensed hospital, shall be present for the administration of anesthetics and recovery of patients when any general or major regional anesthetic is used.

c) All tissues removed during surgery, except foreskin, bone, cartilage, skin, fingernails, toenails, teeth, and scar tissue, which is coincidentally removed during the course of cosmetic or corrective surgery, shall be examined by a consulting pathologist, who shall provide a written report of the examination to the attending physician. A copy of the pathology report shall be filed in the patient's clinical record within seven (7) days. Foreign substances (e.g. wood, glass, pieces of metal including previously inserted surgical hardware, etc.) removed during surgery do not need to be examined by a pathologist.

d) All x-rays, except those exempted by the consulting committee and as specified in the facility's policies and procedures manual, shall be read by a physician, podiatric physician, or dentist, each of whom shall have practice privileges at the facility, or by a consulting radiologist approved by the consulting committee. A copy of the x-ray report shall be filed in the patient's clinical record within seven (7) days.

(Source: Amended at 10 Ill. Reg. 21906, effective January 15, 1987)

Section 205.620 Statistical Data

a) Each ambulatory surgical treatment center shall submit to the Department clinical statistical data including the following:

1) the number and type of procedures performed.
2) the number and type of complications reported.
3) the number of patients requiring transfer to a licensed hospital for treatment of complications.
4) the number of patients returning for follow-up contact.
5) the number of deaths.

b) This clinical statistical data shall be submitted to the Department no later than April 1 of each year for the preceding calendar year.

(Source: Amended at 12 Ill. Reg. 3743, effective February 15, 1988)

Section 205.810 Complaints

a) All complaints against ambulatory surgical treatment centers shall be reported to the Illinois Department of Public Health. Complaints should preferably be in writing and contain sufficient facts to facilitate the investigation. Complaints by telephone will be accepted.

b) Each ambulatory surgical treatment center shall post a notice provided by the Department which reads: "If you have concerns about the care being provided in this licensed ambulatory surgical treatment center you may file a complaint with the Department of Public Health by writing to the following address: [address], or by calling [telephone number] during regular business hours. You may also wish to discuss your concerns with the personnel available at this facility. This notice is posted as required by regulation of the Department of Public Health." The notice shall be posted in each center in a location visible to staff, patients, visitors, and the general public.

(Source: Amended at 12 Ill. Reg. 3743, effective February 15, 1988)

Section 205.1400 Details and Finishes

a) Corridors and Exits
   1) Minimum public corridor width shall be 5′-0″, except those corridors where patients are transported in stretchers or carts shall be 8′-0″.
   2) The facility or section shall have at least two exits remote from each other. Other details relating to exits and fire safety shall be in accordance with Chapter 12, Section 12-6 (New Ambulatory Health Care Centers), and Chapter 26 (New Business Occupancies) of the National Fire Protection Association's Standard No. 101: "Life Safety Code" (1981). Specific provisions of this Part which are more stringent than the requirements of the code shall govern.
   3) Items such as drinking fountains, telephone booths, vending machines, and portable equipment shall be located so as not to restrict corridor traffic or reduce the corridor width below the required minimum.

b) Doors
   1) All doors to toilets which may be used by patients shall be equipped with hardware which will permit access in an emergency.
   2) The minimum width of doors for patient access to examination and treatment rooms shall be 3′-0″.
   3) The minimum width of doors to rooms needing access for stretchers (procedure rooms, recovery) shall be 3′-8″.
   4) Doors on all openings between corridors and rooms or spaces subject to occupancy, except elevator doors, shall be swing type.

c) Doors, sidelights, borrowed lights, and windows in which the glazing extends down to within 18 inches of the floor (thereby creating possibility of accidental breakage by pedestrian traffic) shall be glazed with safety glass, wire glass, or plastic glazing material that will resist breaking and will not create

dangerous cutting edges when broken in accordance with the State of Illinois Safety Glazing Materials Act (Ill. Rev. Stat. 1985, ch. 111½, par. 3101 et seq.). Similar materials shall be used in wall openings unless required otherwise for fire safety.

d) Thresholds and expansion joint covers shall be made flush with the floor surface to facilitate use of wheelchairs and carts.

e) Air dryers, or paper towel dispensers and waste receptacles shall be provided at all handwashing fixtures.

f) Where labeled fire doors are required, these shall be certified by an independent testing laboratory as meeting the construction requirements equal to those for fire doors in National Fire Protection Association (NFPA) Standard No. 80: "Standard for Fire Doors and Windows" (1981). Reference to a labeled fire door shall be constued to include labeled frame and hardware.

g) Radiation protection requirements of X-ray and gamma ray installations shall conform to the requirements of the Department of Nuclear Safety's radiation protection rules (32 Ill. Adm. Code, Chapter I, Subchapter b) and should follow guidelines of National Council on Radiation Protection (NCRP) reports #33 ("Medical X-ray and Gamma Ray Protection for Energies up to 10 MeV Equipment Design and Use") dated February 1968, and #49 ("Medical X-ray and Gamma Ray Protection for Energies up to 10 MeV Structural Shielding Design and Evaluation") dated September 1976. Provisions shall be made for testing and completed installation before use, and all defects must be corrected before use.

h) The minimum ceiling height shall be 8′-0″ with the following exceptions:
   1) Boiler rooms, if provided, shall have ceiling clearance not less than 2′-6″ above the main boiler header and connecting piping.

2) Radiographic and other rooms containing ceiling mounted equipment and including those with ceiling mounted surgical light fixtures shall have height required to accommodate the equipment and/or fixture.
3) Ceilings in corridors, storage rooms, toilet rooms, and other minor rooms may be not less than 7'-8".
4) Suspended tracks, rails, and pipes located in path of normal traffic shall be not less than 6'-8" above the fooor.

i) Flammable Anesthetics are prohibited.
j) Cubicle curtains and draperies shall be noncombustible or rendered flame retardant and shall pass both the large and small scale tests of NFPA Standard No. 701: "Standard Methods of Fire Tests for Flame-Resistant Textiles and Films" (1977).
k) Floor materials shall be easily cleanable and have wear resistance appropriate for the location involved.
1) In all areas frequently subject to wet cleaning methods, floor materials shall not be physically affected by germicidal and cleaning solutions.
2) Floors that are subject to traffic while wet, shall have a nonslip surface.
l) Wall finishes shall be washable and in the immediate area of plumbing fixtures, shall be smooth and moisture resistant.
m) Floor and wall penetrations by pipes, ducts, and conduits shall be tightly sealed to minimize entry of rodents and insects. Joints of structural elements shall be similarly sealed.
n) Ceiling Finishes
1) Ceilings shall be cleanable and those in sensitive areas such as surgical rooms shall be readily washable and without crevices that can retain dirt particles. These sensitive areas shall have a finished ceiling, covering all overhead duct-work and piping.

2) Finished ceilings may be omitted in mechanical and equipment spaces, shops, general storage areas, and similar spaces, unless required for fire resistive purposes.
3) Acoustical ceilings are recommended in corridors, multipurpose rooms and waiting areas.

(Source: Amended at 12 Ill. Reg. 3743, effective February 15, 1988)

Section 205.1410 Construction, Including Fire Resistive Requirements

a) Buildings shall be of the following heights and construction types with automatic extinguishment system identified in the following table:

Construction Type	Stories 1	2	3	Over 3
2-hour Fire Resistive	X	X	X	X
1-hour Protected Noncombustible	X	X	X	
Noncombustible	X	X		
Heavy Timber	X	X*		
1-hour Protected Ordinary	X	X*		
1-hour Protected Wood Frame	X*			
Ordinary	X*			

Key:
X = Permitted types of construction.
* = Building requires automatic extinguishment protection except in procedure rooms. Smoke detectors must be installed in procedure rooms.

b) Walls enclosing stairways, elevator shafts, chutes, and other vertical shafts, boiler rooms, and storage rooms (containing combustible materials) shall be of not less than one-hour fire resistive construction, except in buildings over 3 stories in height, where 2-hour enclosure is required.

c) Building insulation materials, unless sealed on all sides and edges, shall have a flame spread rating of 25 or less and a smoke developed rating of 450 or less when tested in accordance with NFPA Standard 255: "Method of Test of Surface Burning Characteristics of Building Materials" (1979).

d) Elevators and Dumbwaiters
   1) All ambulatory surgical treatment centers located above the first floor of the building shall have an electric or electrohydraulic elevator.
   2) Inspections and tests shall be made, and written certification be furnished, that the installation meets the requirements of all applicable safety regulations and codes.

(Source: Amended at 12 Ill. Reg. 3743, effective February 15, 1988)

Section 205. TABLE A General Pressure Relationships and Ventilation Rates of Ambulatory Surgery Area

Area Designation	Pressure Relationship to Adjacent Areas	Minimum Total Air Changes per Hour Supplied to Room	All Air Exhausted Directly to Outdoors	Recirculated Within Room Units
Procedure Room	+	15	Optional	No
Examination Room	0	6	Optional	Optional
Recovery Room	+	6	Optional	Optional
Medication Area	+	4	Optional	Optional
X-Ray Room	0	6	Optional	Optional
Soiled Workroom or Soiled Holding	–	10	Yes	No
Clean Workroom or Clean Holding	+	4	Optional	Optional
Darkroom	–	10	Yes	No
Toilet Room	–	10	Yes	No
Janitors' Closet	–	10	Yes	No
Sterilizer Equip. Rm.	–	10	Yes	No
Linen and Trash Rm.	–	10	Yes	No
Laboratory	–	6	Optional	Optional
Soiled Linen Storage	–	10	Yes	No
Clean Linen Storage	+	2	Optional	Optional
Anesthesia Storage	0	8	Yes	No
Central Services Area				
Soiled Area	–	6	Yes	No
Clean Area	+	4	Optional	Optional
Equipment Storage	0	2	Optional	Optional

\+ = Positive
– = Negative
0 = Equal

(Source: Amended at 10 Ill. Reg. 8806, effective June 1, 1986)

APPENDIX B

Senate Reading SB-1051

* * * * *

SECRETARY:
SB 1051 (Secretary reads title of bill)
3rd reading of the bill.
PRESIDING OFFICER (SENATOR MOHR):
Senator Wooten.
SENATOR WOOTEN:
Thank you, Mr. President. This is another one of those bills that cuts across lines in all kinds of ways. The Illinois State Medical Society asked that it be presented in a series with the two previous bills, one changing the law relating to abortion, the other changing the Medical Practices Act. While this has a relationship to abortion, it actually goes much beyond that. It provides for the establishment and licensing of facilities which can perform minor surgery. This would be things like tonsillectomy, hernias, abortions would be included, facial surgery, plastic surgery and so on. In other words procedures which would not require an overnight stay. And indeed these ambulatory surgical treatment centers are forbidden to keep patients overnight. However, those of you who have kept close to medical practices know that untoward things can occur at any time, and so provision is made in here that doctors who function in such a center must also be licensed to practice in a hospital nearby so that if any complications occur they can quickly move the patient to that place. Now, I handed out an outline to explain to you how these things would work, definitions, they must get a license, some of these things are left open as to regulations. The Department would like to take a hand in that. This is something doctors have been urging us to do for a couple of years now, and ambulatory surgical treatment centers are . . . are in effect out west. The idea is they

can be a great saving to a patient. One of the big costs in a hospital, if you remember it's kind of like a hotel which has special services. And if you don't need that overnight stay, you can save a great deal of money. So there's a great savings possible for the patient who needs this kind of a one-day surgical treatment. It does include abortion, and everything would be rather closely regulated and inspected. I'll be glad to answer any questions I can on this.

* * * * *

APPENDIX C

80th General Assembly

Report to the House Human Resources Committee

Subcommittee on Health
December 13, 1978

"State regulation of abortion clinics"

MAJORITY MEMBERS:	MINORITY MEMBERS:
MICHAEL HOLEWINSKI *Subcommittee Chairperson*	PENNY PULLEN DONALD DEUSTER
ELLIS LEVIN	JAMES EDGAR
PEGGY SMITH MARTIN	CALVIN "CAL" SKINNER
DAVID ROBINSON	ROGER STANLEY
ANNE WILLER	
RICHARD MUGALIAN	
EUGENIA S. CHAPMAN *Chairperson* *Human Resources Committee*	CHARLES E. GAINES *Minority Spokesman* *Human Resources Committee*

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SUMMARY OF RECOMMENDATIONS

1) Insure that the State is devoting sufficient resources to regulatory programs.
2) Reform the basic approach and method of State inspections of regulated clinics.
3) Increase the frequency of facility inspections.
4) Insure the full use of IDPH inspectional records and reports. Make them public.
5) Require a reasonable licensure fee for clinics to offset regulatory costs.
6) Stiffen penalties for operating a clinic without a license.
7) Require criminal background and character checks of clinic licensees.
8) Require clinic ownership and financial statements.
9) Authorize the immediate closure of clinics that pose a menace to patient health.
10) Require the IDPH to take into consideration discipline of clinics by other IL State agencies, or other states. Require an affirmative program of interstate cooperation.
11) Mandate the termination from Medicaid of any vendor not properly licensed.
12) Outlaw kickbacks and referral fees. Clamp down on unscrupulous referral agencies.
13) Require OB-GY board certification or eligibility for physicians performing abortions.
14) Require gross and microscopic, on-site analysis of aborted tissue. Patients should be informed of all test results.
15) Require a specific interval between initial patient exams and the surgery.
16) Specify more detailed counseling requirements on all cases.
17) Improve consumer protection and education/information services.
18) Require medical vendor reporting of cases of abortion complications.

19) Delete the veto authority of the clinic licensure Board on new rules & regulations.
20) Compel the Department of R&E and its Medical Disciplinary Board to improve programs of physician regulation.
21) Require reporting of certain complaints to the Medical Disciplinary Board for review by the Department of R&E.
22) Repeal & amend existing statutes to clarify current abortion law. Correct an obvious discrepancy in the Abortion Law of 1975.
23) Encourage established, reputable medical vendors to provide needed services.

INTRODUCTION

To the House Human Resources Committee
Eugenia Chapman, Chairperson

The following pages present the preliminary recommendations of the Subcommittee on Health to the full House Human Resources Committee on the general topic "State regulation of abortion clinics". The issues and recommendations have been compiled after two public hearings involving the investigators who exposed the abuses of the clinics on Michigan Avenue and State officials, medical experts, clinic operators and referral service agency representatives.

The Subcommittee's review of this matter has been limited, but the proposed revisions are substantive. They should help upgrade the regulation of the facilities and professionals and improve the quality of the services, without effecting severe restrictions on the availability or accessibility of services to women electing to terminate their pregnancy.

The most critical observation of the Subcommittee is that: State regulation of the investigated clinics does not have the high priority it requires, and the injuries and abuses have been permitted, almost encouraged, by the negligence and indifference of the agencies responsible for the control and prosecution of unscrupulous practitioners.

There are, however, many individuals, agencies, organizations and the various levels of government that must share in the blame for the injuries, fatalities, and slipshod services that have been investigated and reported by the Better Government Association and the Chicago *Sun-Times*.

The General Assembly's continuous attempts to overrule the Courts and interfere with the right of women to obtain medical services has confused the regulatory efforts and, thereby, opened the door to abuses by the "abortion-mill" operators. The Judiciary has permitted corrupt and incompetent physicians to remain in practice for months or years because of its inability to effect swift decisions in relation to disciplinary proceedings. The Attorney General, or other public prosecutors, have not aggressively pursued cases of vendor fraud or physician incompetency and malpractice. The State Departments of Public Health and Registration & Education, who have the primary jurisdiction for regulating the clinics and medical professionals, have neglected their duties and not conducted their programs with the intensity that this matter deserves. A majority of hospitals and private physicians have neglected this area of medical practice and, because of their preferences not to render pregnancy termination services to women, they have practically driven victims into the hands of the "profiteering" clinics. The media has permitted the promotion of the shoddy vendors. And the federal government, including the Congress, persists in its efforts to invoke unreasonable regulations on the welfare benefit programs that support some of these medical services.

Finally, the Subcommittee is disappointed by the current attitude and strategy of the Governor and the agencies under his control in the response to this medical emergency. The interagency special task force is proceeding at a cautious, but extremely slow pace in preparation of its recommendations and program changes to the Governor. The IL Department of Public Health, for example, has acknowledged that it needs more manpower and resources to beef up its investigations and overall program

of regulation, but the decision to commit the requisite funding is still being evaluated by the Bureau of the Budget and has yet to be concurred in by the Governor. Other recommendations have been developed and forwarded to the staff of this special task force, but the analysis is incomplete. In the words of the task force staff: "We are wrestling with a lot of problems and solutions." In the meantime abuses and injuries may be occurring. The weaknesses of the existing programs continue. By the time the task force completes its entire review and packages the recommendations, the impetus for action may be lost. The pressure is on the abusive clinics and the State should be prepared to sustain its initiatives and maintain the momentum that the expose created to crackdown on shoddy and corrupt practices. Only an aggressive policy and strategy can accomplish this objective, and there is little evidence that this is forthcoming from the State agencies, the task force or the Governor's Office. Your immediate review and implementation of this report should be considered an emergency matter in the 81st General Assembly.

Sincerely,

/s/ MICHAEL S. HOLEWINSKI
Michael S. Holewinski

RECOMMENDATIONS

1) INSURE THAT THE STATE IS DEVOTING SUFFICIENT RESOURCES TO CLINIC REGULATION

The Director of the Department of Public Health has indicated that new resources are required for the conduct of a beefed-up regulatory effort with respect to the ambulatory clinics. Although these resources have been requested of the Bureau of the Budget, no approval has been issued after several weeks of evaluation. The Director testified that resources would have to be diverted from other programs in order to directly respond to the BGA/*Sun-Times* findings, but there had been no commitment for a permanent increase in funding to provide for an expansion of the basic program or increase in the inspectional activities.

The Subcommittee endorses the initiatives of the Chairperson of the House Human Resources Committee to sponsor legislation appropriating the $50,000 for Fiscal Year 1979 which the Director of the Department of Public Health has requested of the Bureau. (The Director testified he would support the Bill at the Chicago public hearing Dec. 4th, even though this matter had still not been resolved by the Governor.) The additional appropriation would enable the IDPH to hire at least 4 new inspectional staff and begin other program initiatives in response to the problems identified in the recent probe. The Subcommittee would review the FY 80 Budget for this program very closely to insure that a sustained, aggressive level of regulation had been fully developed.

2) REVISE METHOD OF STATE INVESTIGATION, PARTICULARLY AS CONDUCTED BY IDPH

The regulation of clinics or review of medical vendors by the various State agencies (Public Health, Public Aid and Registration & Education) has been neither aggressive nor thorough. Independent investigations

by groups like the IL Planned Parenthood Council affiliates and the Better Government Association have been more effective in identifying both poor and good quality services.

The present program of the IL Dept. of Public Health devotes too much attention to inspections of the physical plants and patient records, rather than an ongoing evaluation of clinic operations and patient care. The periodic, brief visits of the agency personnel cannot possibly capture the true character of the facility.

The current approach and attitude of these regulators must also be questioned. If they perceive the task of inspecting facilities as that of a "friendly" visitor or "consultative" in nature, the ability to effect strong discipline against violators of the law or regulations are inhibited.

The entire IDPH methodology should be re-evaluated and reformed. The experiences of the BGA, *Sun-Times* and other groups may give some clues in this regard. For example, the BGA investigations were conducted "undercover" over a period of several weeks. Agents experienced the day-by-day operations of clinics and observed patient care continuously for months. In the case of Planned Parenthood, reviews are conducted by an interdisciplinary team that can look at every aspect of the clinic with a relatively high degree of special expertise.

The occasional physical plant and records spot-checks are appropriate but of limited value in comprehensively evaluating the administration and patient care. A brief 4-6 hour inspection, as the experience of the Department of Public Health clearly demonstrates, is not capable of detecting the deliberate falsification of records, sloppy management practices, shoddy sterilization techniques, or the insensitivity of medical or counseling personnel. The existing system of the "brief encounter" must be expanded. New techniques must be developed to curb the abuses.

First, State agencies should coordinate their efforts and resources, and conduct integrated, combined investigations whenever possible. Second, interdisciplinary teams of specialists in the various field of medicine, social work, business administration, management, or accounting should be used so that every aspect of the facility is scrutinized. Inspectors should be deployed to clinics for several days or weeks at a time so that they may conduct a sustained investigation. The inspector could observe patient care on a continuous basis to assure him/herself that operations are normal or routine and not "staged" for the brief period of the visit. Finally, the Departments of Public Health, Public Aid and Registration & Education should arrange for undercover investigations. In cooperation with the IL Department of Law Enforcement, investigators should test the system by posing as consumers of services or as personnel within the clinics in a manner similar to the BGA/Sun-Times effort. This type of investigation has been used successfully in some cases involving Medicaid fraud or the regulation of controlled substances by the Department of Registration & Education.

Above all, there should be no mistake on the part of the State regulatory staff that they are *enforcement* officers. An adversary relationship should be clearly established so that there is no hesitation in getting tough. This is not to say that clinics should be harrassed or clients aggravated, but it should be clear that the inspector is not a consultant or friendly visitor.

3) INCREASE FREQUENCY OF FACILITY INSPECTIONS BY IDPH. EXPRESSLY EMPOWER THE DEPT. OF PUBLIC HEALTH TO CONDUCT UNANNOUNCED INSPECTIONS.

The Department of Public Health only recently stepped up its efforts in the inspection of ambulatory surgical treatment centers, particularly those which spe-

cialize in abortion services. In his prepared testimony the Director, Dr. Paul Peterson, indicated that resources have been diverted from other licensing programs in order to conduct more frequent inspections and that a schedule of quarterly (4/year) visits would be established. Prior to this change most facilities would be visited once or twice per year.

It is clear that the Department does not have the personnel or funding to sustain the new investigative effort. As the Director indicated, resources have been drawn from other programs to maintain the new inspection schedule. This program has suddenly become a high priority and its enhancement is being accomplished at the expense of another. It is just this discretionary shifting of priorities which caused the neglect of the regulatory effort towards abortion clinics.

The current Ambulatory Surgical Treatment Center Licensing Act should specify that the Department conduct a minimum of four (4) inspections per year of every facility. To the extent required, facilities with serious deficiencies or a chronic and continued history of violations should be inspected more frequently. In some instances, particularly in the case of the ambulatory surgical treatment centers that provide a full range of outpatient services, the quality of care and the competent administration may not warrant a comprehensive inspection every quarter and the Department should be given the discretion to limit the nature or scope of the required visit.

The Dept. of Public Health has expressed a belief that it has sufficient authority to conduct *unannounced* inspections of the ambulatory clinics. The current law does not really define the nature of its inspections and, according to some legal authorities, this assumed authority may be challenged under recent Federal Court Opinions unless a more specific mandate and procedure for unannounced inspections is delineated under law. The Ambulatory Surgical Treatment Center Licensing Act should be amended to expressly define this type of regulatory activity.

4) IDPH RECORDS AND REPORTS SHOULD BE MADE PUBLIC AND FULLY USED IN REGULATION

The 1975 Abortion Law provides that ". . . all information obtained by a physician, hospital or ambulatory health facility from a patient for the purpose of preparing reports to the Department . . . or reports received by the Department shall be confidential and shall be used only for statistical purposes . . ." (Chapter 38, par. 81-15, *1977 IL Revised Statutes*). Similarly, the Ambulatory Surgical Treatment Center Licensing Act (Chapter 111½, par. 157-8.9, *1977 IRS)* states that: ". . . Information received by the Department through filed reports, inspection or . . . otherwise . . . shall not be disclosed publicly in such manner as to identify individuals or ambulatory surgical treatment centers, except in proceeding involving the denial, suspension, or revocation of a license to open, conduct and maintain . . . (such a) . . . center . . . ."

The Department of Public Health has repeatedly indicated that the current law effectively limits use of the data it collects about these clinics. It cannot exchange data with other regulatory agencies. Nor have the reports submitted by physicians been referred to its regulatory staff so that they can identify deficiencies or trends to guide planning and programming for improved inspections. Also, most of the information about facilities' services, personnel, sanitation, compliance with regulations, ownership, etc. is not open to public inspection or publicly distributed. The Department cannot develop a public information program disclosing the quality of care, the distribution of services, or the licensure status of a center without abridging the letter of the law. This is extremely restrictive.

Patient confidentiality must be protected. Beyond this most important requirement, the regulatory reports and inspectional files should be open to public inspection so that persons seeking services can be assured that they are going to be dealing with reputable and

high quality vendors. The Department of Public Health must also be able to exchange data with other State agencies when its general findings may relate to possible violations of professional medical standards or the regulations of State-funded programs like Medicaid. The inspectors cannot rely solely on their on-site visits to detect problems and determine priorities. The data in the filed reports could be an important clue to irregularities or improprieties of clinics. Data should be exchanged freely within the Department. Data that is open for public inspection must be precise, accurate and comprehensible.

The current limitations should be amended to delete restrictive language, while preserving patient confidentiality. The Department should develop a report for public distribution regarding clinic services and their licensure status. A high priority should be the immediate public disclosure of any facility license that has been suspended or revoked, and an identification of those facilities that have been put on notice by the Department that their licenses are in jeopardy.

5) REQUIRE A REASONABLE LICENSURE FEE FOR AMBULATORY SURGICAL TREATMENT CENTERS

Unlike most other licensed health facilities or practitioners, ambulatory surgical treatment centers do not pay a fee to offset some of the costs of the Department of Public Health regulatory program. They do not even pay for the cost of the mailing and handling charges in the application process.

The Governor's Cost Control Task Force recognized the fundamental principle that regulatory programs be supported by licensure revenues. It noted that funding and personnel shortages in the Department of Public Health made it impossible for many required inspections to be completed, and recommended that appropriate fees be established in all health services to supplement other State revenues to beef up regulatory efforts.

The constraints on State revenues generally have caused cutbacks in IDPH personnel and programs, particularly in the area of licensure inspections. It has been the general posture of the Bureau of the Budget and the Administration to require new regulatory program initiatives to be as self-supporting as possible. In this regard, the Department of Public Health should establish licensure fees for all facilities or professions for which it currently has responsibility. It should also raise existing fee levels to a more reasonable level to offset current costs, and to enable its activities to be increased.

Ambulatory surgical treatment centers should pay at least a minimum initial licensure fee of $*500* and an annual renewal fee of $*300*.

6) STIFFEN PENALTIES FOR OPERATING A CLINIC WITHOUT A LICENSE

Operating a clinic without a license is currently punishable as a Class A Misdemeanor ($1,000 and/or up to 1 year in prison). One clinic operator involved in the recent investigation was found guilty in 1974 and assessed a fine of only $500. With respect to facilities that are currently making hundreds of thousands, millions in some instances, the current penalty is no real deterrent to the scandalous practices reported in the *Sun-Times* series.

The penalties should be increased substantially. HB 3446 included a provision which would classify the offense of operating without a license as a Business Offense punishable by a $10,000 fine and each day's violation constituting a separate offense. It also provided that other violations of the licensure law would also be punishable by a fine of *not more than* $10,000.

7) REQUIRE CRIMINAL BACKGROUND AND CHARACTER CHECKS OF CLINIC LICENSEES

The criteria for licensure of an ambulatory surgical treatment center pertains only to its physical plant characteristics and other obvious factors of administration. The Director must issue a license to a facility if it: meets the minimum IDPH-approved standards; is under the medical supervision of at least one physician; only physicians perform the surgical procedures; and it maintains adequate medical records for each patient. The standards of the Department are limited to the physical aspects of the clinic; the number and qualifications of the personnel; the sufficiency of the equipment; and the nature and availability of other facilities, programs and services.

Unlike nursing homes and hospitals, the Department is not expressly authorized to take into account the character or criminal record of a prospective licensee or the operators of the facility.

An application for a *nursing home license* may be disapproved by the Department if the applicant has been convicted of a felony or of 2 or more misdemeanors involving moral turpitude, and if the Department determines that the person has not been sufficiently rehabilitated to warrant the public trust. It may also be turned down if the moral character of the applicant, the manager or supervisor of the facility is not reputable.

Hospital licensure applications may be approved if the Department finds that: ". . . the applicant is fit, willing and able to provide a proper standard of service for the community with particular regard to the qualification, background, and character of the applicant . . . ."

The background of a prospective clinic operator has obviously not been a significant matter in the issuance of licenses. The fact that an employee of the facility, or the prospective owner, is under investigation by the IL Department of Public Aid or the Department of Law Enforcement, or has been convicted of Medicaid fraud would apparently have no

bearing on the licensure—it obviously did not in the case of one of the physicians identified in the BGA investigations. If a vendor previously had a clinic license suspended or revoked for gross violations of the law, he/she could presumably be back in business so long as the facility to be licensed met the other general standards of the Department.

8) REQUIRE OWNERSHIP AND FINANCIAL STATEMENTS OF CLINICS

The Department of Public Health currently requires under its rules and regulations an identification of those persons having at least a *10%* interest in an ambulatory surgical treatment center to be licensed, although this is not specifically referenced in the governing licensure Act. There is also a requirement that the facility maintain an accounting system that will permit "satisfactory" auditing, but this regulation is not expressly required by statute. No specific procedure is delineated for updating this information or keeping the IDPH records current.

It is significant to note that nursing homes are required to submit detailed financial and ownership statements in conjunction with licensure. This data is extremely important, not only to the Department of Public Health but also to the IL Department of Public Aid in its evaluation of provider reimbursement rates and investigations for fraud and corruption in the Medicaid program. These clinics require the same type of scrutiny given nursing homes since they are perpetrating the same types of abuse and fraud.

The Ambulatory Surgical Treatment Center Licensing Act should be amended to incorporate requirements for ownership and financial statements identical to the nursing home licensure law. There should be no arbitrary limitation on the extent of ownership that must be disclosed. If a vendor of medical services previously terminated from the Medicaid program maintains

any degree of interest in an ongoing clinic, this should be a matter of public record and subject to immediate investigation by the appropriate State authorities.

9) AUTHORIZE IDPH TO IMMEDIATELY CLOSE CLINICS THAT POSE MENACE TO PATIENT HEALTH

In the 1975 Session of the 79th General Assembly the Department of Public Health introduced legislation which would have enabled it to immediately close a facility if an inspection indicated that its continued operation constituted an imminent and serious menace to the health or safety of patients, or in the event of an owner/operator being convicted for operating without a license or over violation of the licensure Act. The Department clearly recognized the limitations of the existing law to effect the closure of a facility under any circumstances.

As the recent investigations have demonstrated, clinics have continued in operation even after the Department of Public Health has exercised its primary sanction of removing the clinic license. It is clear that business interests have become more important than the health and safety of the patients, when the abuses may continue while the administrative and judicial appeal of a proposed licensure suspension or revocation is underway. The process for disciplining a clinic takes so long that many lives are unnecessarily jeopardized while the harmful conditions and practices continue. The State must be able to act swiftly and with the safety and health of the patients uppermost in its priorities.

HB 780 of the 79th General Assembly, or a provision that is similar as in HB 3446 of the 80th General Assembly, should be pursued to insure that the Department of Public Health has an effective remedy in an emergency situation.

10) REQUIRE IDPH TO TAKE INTO CONSIDERATION DISCIPLINARY ACTIONS OF OTHER IL STATE AGENCIES, OR OTHER STATES. REQUIRE AN AFFIRMATIVE PROGRAM OF INTERSTATE COOPERATION

The Department of Public Health issued a license to the Michigan Avenue Medical Center even though the owner/operator of the clinic was under investigation for Medicaid fraud by the IL Department of Public Aid. In fact, this person had been found guilty of Medicaid fraud but the authority of the Department of Public Aid to terminate his eligibility from the program was questioned until the General Assembly, in emergency Special Session, specifically delineated the grounds and procedures for this type of vendor discipline. His participation is still being contested. In the meantime his clinic has thrived under the auspices of the State license issued by the Department of Public Health.

In addition to the other criteria that the IDPH may use to disapprove an application for, or suspend or revoke a license, it should take into consideration the disciplinary actions of its sister agencies. If a clinic employs persons who are not properly licensed by the Department of Registration & Education, who have been suspended or terminated from the Medicaid program, or who are under investigation for fraudulent practice, the Department of Public Health should not continue to sanction their continued operation. This authority should be clearly delineated under the Ambulatory Surgical Treatment Center Licensing Act. Legislation authorizing the disciplining of medical professionals by the Department of R&E for Medicaid fraud was enacted this past spring (HB 3157, PA 80-1425), and a similar provision should be incorporated into *each licensing act* which the Department of Public Health administers.

Further, the State of Illinois should take into consideration the disciplinary action of other states with

respect to clinic licensure and Medicaid eligibility. If a medical vendor or clinic operator has been denied participation in welfare assistance programs for fraud or abuse, or been denied a license or had a license suspended or revoked these facts should be key criteria on the regulatory actions of the IL Departments of Public Health or Public Aid (there are already reciprocity considerations in effect with respect to physician licensure by the Department of R&E).
The state should take affirmative action to consult with other states' authorities about its problems in the regulation of facilities, services and vendors. To the extent that it is possible, uniform standards should be developed and reciprocal agreements worked out for the exchange of data and the conduct of investigations.

11) MANDATE TERMINATION FROM MEDICAID ANY VENDOR NOT PROPERLY LICENSED

The Public Aid Code *authorizes* the termination or suspension from Medicaid for any medical vendor who is not properly licensed, but this requires a separate determination and hearing by the Department of Public Aid. While this particular issue is under consideration, the vendor could be charging for services he performed and receiving State payments on behalf of welfare clients. There should be no question about the eligibility of the vendor to participate in Medicaid. The lack of the proper professional credentials should make termination automatic, with no basis for appeal.

NOTE: The IL Department of Public Aid has already endorsed this recommendation, as it has been drafted in a proposed bill (HB 3447) of the 80th General Assembly. An amendment has been submitted by IDPA, which should clarify the implementation of such a provision.

12) OUTLAW KICKBACKS & REFERRAL FEES. CLAMP DOWN ON UNSCRUPULOUS REFERRAL AGENCIES

The historical prohibition on advertising and promotion of medical services has evidently not applied to abortion services. And the lack of competition which has generally characterized most aspects of the medical industry is apparently not true for the very competitive "abortion mills" of Michigan Avenue. The newspaper advertisements, soundtruck systems and leafletting, and other sales techniques used by some counseling and referral agencies demonstrates this fact very clearly. As the recent investigation made clear, the promotion and sales of abortion to women with problem pregnancies is widespread. And this high pressure business practice has resulted in the improper and erroneous testing of women and the purchasing of abortions that weren't necessary. Women were continuously referred to the worst clinics for kickbacks or for fees which were paid by the clinics in the name of "counseling". Women were sold abortions with little concern for their safety or alternative services. Some women were referred out-of-state to clinics which were not reputable or of high quality and which were under investigation for violations of law by government authorities. These referrals were often made when the same type of services were available in Illinois from clinics or providers in good-standing under the law.
Kickbacks or the payment of referral fees is prohibited under IL Medicaid program, but there is no general prohibition under Illinois law with respect to the private-paying patient. Physicians are generally prohibited from engaging in such practices under the Medical Practice Act, but these activities may be generally undertaken by the owners/operators of the clinics without direct involvement of the medical professionals.

There is no advantage to the continued operation of the profiteering agencies that were the subject of the recent investigations, especially when there are other more reputable, thorough services being offered by agencies like Planned Parenthood and the Health Evaluation & Referral Services in Chicago (HERS). To the fullest extent possible these sales agents and their high pressure promotion of abortions should be outlawed.

In addition, there should be some additional regulation of the entire practice of abortion counseling and referral to screen out the unscrupulous vendor. Some have suggested the licensure of the individual counselors, but this would pose an extremely major administrative and costly bureaucratic problem which would not insure the quality of services desired—professional licensure in Illinois guarantees only a minimum degree of quality control and rarely works to effectively prohibit fraudulent practice.

An alternative to licensure may be the accreditation of the service by a governmentally-sanctioned professional group similar to the role of the Joint Commission on the Accreditation of Hospitals. Ambulatory Surgical Treatment Centers are not generally accredited and professional standards of practice for the various programs and services have not been promulgated. State licensure requirements do not incorporate any such standards although there are minimums specified for some of the medical personnel. Minimum standards for counseling services are procedural in nature and do not presume any minimum qualification of staff responsible for providing them.

13) PHYSICIANS PERFORMING ABORTIONS SHOULD BE BOARD-CERTIFIED OR ELIGIBLE OB-GYN SPECIALISTS

The practice of some abortion clinics utilizing medical residents or other general practitioners with little or no training in women's medicine should not be con-

doned if this is simply a means of cutting costs and perpetuating assembly-line, slipshod operations. If clinics are going to operate as specialty medical services it seems fitting that they should employ and utilize personnel with specialized knowledge and skills.

The Department of Public Health should evaluate the feasibility of a requirement that physicians performing abortions at licensed clinics have or obtain obstetrical-gynecological board certification or eligibility. The Department should determine if there is sufficient manpower available throughout the State to insure that every clinic can effectively operate under such a standard. If it is feasible, the current rules and regulations should be amended to mandate this as a minimum physician personnel qualification.

14) REQUIRE GROSS AND MICROSCOPIC ON-SITE ANALYSIS OF ABORTED TISSUE. PATIENTS SHOULD BE INFORMED ABOUT ALL TEST RESULTS

The current Abortion Law of 1975 requires that aborted tissue be submitted for analysis and report to a board certified or eligible pathologist as a matter of record in all cases. This is usually accomplished through independent laboratory analysis, after some delay in the transmission to an outside firm. The results of this testing are not immediately available to the physician or the patient, if the tissue is even submitted by the clinic or if it is processed effectively or competently so that results are not lost, fabricated or erroneous.

It is important that a preliminary tissue analysis be completed immediately after the abortion. A gross, or simple visual examination of the material will not reveal any possible complications or the possibility of an incomplete procedure. A trained analyst, with the benefit of the appropriate microscopic technique, would be able to discern some problems and, of par-

ticular importance, whether the abortion actually was necessary or successful. The conduct of this procedure on-site would minimize the possibility of the tissue being destroyed or misplaced for the eventual comprehensive analysis.

Once *all* tests have been completed, including the pregnancy and pathology tests, the attending physician should *inform the patient of the results.* This information is required for the record but, as the experiences of the BGA investigators revealed, many women were never aware of the need for the surgery or its outcome. Even if complications had developed they might never know until it was too late and they experienced extreme pain or discomfort and/or a medical emergency. Some women were given the results, on the sly, by non-medical or non-supervisory staff of the clinic. All patients have a right to know about their health. An informed consent about surgery is impossible if test results are either not available or not disclosed. Current law should expressly provide for this disclosure, with consideration for possible extenuating circumstances where some patients may actually prefer not to be so informed or who may experience psychological stress as a result.

15) A SPECIFIC INTERVAL BETWEEN INITIAL PATIENT EXAM & SURGERY SHOULD BE ESTABLISHED AS A PATIENT CARE GUIDELINE. A SPECIFIC POST-OP RECOVERY TIME SHOULD ALSO BE SPECIFIED

In the normal course of any medical practice, except in emergency circumstances, the initial patient contact and subsequent treatment occurs at different visits. There is usually an interval between the time that a particular condition is detected and diagnosed, and then treated. A series of visits will generally be arranged for further testing and consultation at which the physician will have a full discussion with the patient about the medical problem, alternative therapies, the risks of each, and the schedule for the commencement and conclusion of the care. This normal procedure is apparently not being followed in some of the investigated clinics or with respect to abortions generally, except in cases where there has been client contact with groups like Planned Parenthood or HERS (Health Evaluation & Referral Services). Patients arrive at the facility and receive the treatment, with or without the formalities of an initial exam, the conduct of appropriate testing and counseling prior to the abortion.

It is the rush to the surgery and the expedited processing of the patient which is too often causing the slipshod and injurious techniques by the physicians and clinical personnel.

The assembly-line practices of these clinics must be altered. Although it is convenient for a woman to go to a clinic for a brief treatment, the stress and threat of injury under some of the current practices must be considered as problems which cannot be disregarded for the sake of convenience. The normal precautions of medicine should be followed in abortions as in other types of conditions and illnesses. We do not rush to the surgical table for the treatment of other disorders or elective treatments, and therefore should not single it out in the interest of expediency and profit. Abortions are not medical emergencies, unless there are complications or the duration of the pregnancy necessitates an immediate response.

An abortion should be approached at least as a three-step, 2 visit process: Step-1 for the initial visit for an examination and testing: Step-2, as part of a separate visit for the surgery, if it is indicated; and Step-3, the post-operation recovery. The interval between the first two steps is difficult to determine, since there may be many mitigating circumstances that would have a bearing on the timing of the treatment. A minimum period, of perhaps 24 hours in length, should be considered as a specific guideline in treatment.

As important as the interval for a pre-operative exam and consultation, is the post-operation recovery and discharge. Women are too often being pushed out of the clinics before they are medically or emotionally ready. There are no set periods for post-op recovery nor specific criteria for discharge. This is generally a matter of professional discretion, which many of the clinics have not competently or carefully administered. Patients should be given a minimum of ½ hour for recovery from the surgery and anesthesia and specific provisions should be made for the extension of this time if the women either requires or desires it. Discharges should occur only after competent medical determinations are made by a physician that the patient is able to safely leave the facility, based upon a separate examination and discharge order. The circumstances of this discharge should also become a part of the patient record.

NOTE: The Subcommittee could not agree on this particular matter and recommended that it be studied further.

16) COUNSELING SERVICE REQUIREMENTS SHOULD BE MORE SPECIFIC AND DETAILED

The Ambulatory Surgical Treatment Center Licensing Act makes no reference to any counseling requirement in connection with an abortion or any medical service offered in such a facility, while the Abortion Law of 1975 refers only to a requirement for the informed consent of any woman seeking an abortion prior to the surgery. The Department of Public Health Rules and Regulations refer to various aspects of medical review and consultation, but do not really refer to "counseling" or the type of patient contact which would acquaint a woman with a problem pregnancy of the options, risks or circumstances of her choices. The law is relatively silent about the type of services which clearly identify organizations

like Planned Parenthood and H.E.R.S. as high quality and preferred service agencies.

A general requirement for the counseling of each client seeking an abortion should be referenced in the laws governing the licensure of clinics and the conduct of abortion services by physicians. Rules and regulations of the Department of Public Health should provide further delineation of the minimum requirements for counseling sessions, including some minimum requirements for the personnel who provide such services (i.e., that they have to be trained in such counseling by an approved agency or educational institution; or that they have a degree in a related field and have had some experience.) Such services need not be limited to the nature and circumstances of the medical procedure, nor the completion of the forms and other details necessary for the securing of an informed consent relating to the surgery. Women with problem pregnancies should be informed that there are comprehensive counseling services available to them. On-site counseling would be designed to assist the woman with her decision-making and to assure that the abortion option is, indeed, an informed choice and exercised freely without coercion or because of the sales-pitches of some disreputable referral agency.

17) IMPROVE CONSUMER PROTECTION & INFORMATION SERVICES

Pregnant women who are uncertain about their options or uninformed about the types of services and facilities that can help them are easy prey for the charlatans and rip-off artists. Many women are sold abortions after being subjected to high pressure sales tactics rather than careful, reasoned counseling which may direct them to less drastic alternatives.

Groups and organizations like the IL Planned Parenthood Council and the Health Evaluation & Referral Services perform necessary and effective services in

the counseling and referral of women with problem pregnancies. Services of this type should be encouraged and developed further to increase their availability and use.

Public education programs are extremely important whether women have problem pregnancies, or not. Prior knowledge of the nature and availability of services may make it possible for teenage females and others to either avoid a pregnancy or injury if they are going to seek medical attention. Family Planning Programs should be expanded, particularly among school-age children who have obviously not been getting the type of training and education they need to cope with their sexual experiences and problems.

The IL Department of Public Health, in cooperation with other State agencies should establish a formal complaint or grievance system with respect to counseling, referral and medical services related to problem pregnancies that may, or may not, result in an abortion. A "hot-line" has been established in the Department of Registration & Education to respond to formal complaints about medical vendors, which may be a component of such a system. It could be expanded to insure its accessibility to other sources of complaints or inquiries and to insure an immediate and thorough response by the appropriate investigative or administrative agency.

Additionally, the Department of Public Health should initiate consumer surveys or feedback systems which would alert it to the problems or benefits of the facilities it regulates. Patients, physicians, clinic personnel, referral agencies, hospitals and other agencies involved in abortion services should be regularly questioned about their experiences, opinions, or recommendations regarding improvements in regulations or services. The Department should not wait for problems to develop or complaints to be registered before discovering fundamental weaknesses or failures in its program. It must aggressively determine whether a high quality of care is being provided. This will be particularly important as the most recent crises involving the investigated clinics unravels.

18) REQUIRE MEDICAL VENDOR REPORTING OF CASES OF ABORTION COMPLICATIONS

Although most reputable ambulatory surgical treatment centers provide post-treatment counseling and follow-up medical services, some women who were treated at the investigated clinics became emergency cases due to serious complications which had been overlooked or ignored. Area hospitals assumed responsibility for the treatment of problems which could have been prevented or lessened if the clinic physicians had been more careful and thorough in their diagnosis and surgery, in their analysis of the aborted tissue, and much more sensitive and professional in their discharge of patients.

Under current law physicians performing abortions must report any complications to the Department of Public Health. This information is not required of the physicians or other practitioners who *did not* participate in the initial procedure but who become responsible for the care and treatment of the woman due to the complications or due to the failure of the initial treatment to terminate the pregnancy as intended. Although the clinics have reported cases where complications occurred, there is no indication if, when or where the follow-up was provided. One case was referred to in the *Sun-Times* in which a woman was not afforded ample post-op recovery time and hemorrhaged on her way home on a CTA bus. She required emergency transport and care by a local hospital and required a complete hysterectomy by the time her experience was over. Another involved a woman who had been given an abortion at one clinic, had been prematurely foreed out of post-op recovery room and passed out. Six weeks later she was told by her private physician that, despite her traumatic experience, she was still pregnant. In both instances the hospital and the physician report of these cases could have been significant evidence for State officials responsible for either regulating the clinics or the li-

censure and discipline of the physicians who had provided the initial treatment.
Any medical practitioner who comes in contact with a case where a complication has occurred, or where the treatment was unsuccessful to any degree, should report it immediately to the appropriate authorities for investigation. These reports should also be compared to those originating from the clinics. The reports of the clinics should include a documentation of the follow-up services provided and any referral to another location or facility for care.

19) DELETE VETO AUTHORITY OF AMBULATORY CENTER LICENSURE BOARD ON NEW RULES & REGULATIONS

The Ambulatory Surgical Treatment Center Licensing Board (12 persons appointed by the Governor: 4-physicians; 1-podiatrist; 1-dentist; 1-Registered Nurse; 1-center administrator; and 4-representative of the general public) is expressly authorized to sign-off on all IDPH rules and regulations prior to their adoption and implementation, although its general function is to "... advise and consult with the Department in the administration ..." the Act. This veto authority has effectively prevented the Department from modifying its program during the past two years.
The membership of the Board has not been at full complement since the Administration of Governor James Thompson took office. Appointments of new members have been delayed for several months. Final appointments were not made until late last Spring and the Board has not really been operational during this past year. The next scheduled meeting is in January, at which time proposed rules changes will be considered.
The enactment into law of the Administrative Procedures Act governing the promulgation of new State rules and regulations, and the provision for public

review and comment on such matters, should provide sufficient safeguards against unreasonable actions by the Department. The professional or special consultation of the Board may continue, but its approval of rules effectively stymies any emergency revisions that may be necessitated given a crisis in patient care like that discovered by the recent investigations of abortion clinics.

NOTE: The Subcommittee could not reach full agreement on this matter, but acknowledged that the lag in the appointments by the Governor to the Board could pose a major stumbling block to any reforms.
The Hospital Licensure Board exercises a similar veto authority, but the circumstances of the ambulatory clinics is not exactly comparable, so that the two Boards don't necessarily have to exercise equal authority.
The Subcommittee recommended this matter for further study, and believes that the role of all such licensure boards should be evaluated in terms of the entire rule-making procedure currently delineated under the Administrative Procedures Act.

20) IMPROVE DEPARTMENT OF R&E AND MEDICAL DISCIPLINARY BOARD REGULATION OF PHYSICIANS

The Department of Registration & Education has taken 33 disciplinary actions against physicians in the past two years and three of those cases have involved violations of the law in relation to abortion services. This record is not particularly outstanding, to say the least. In fact it reflects serious problems in the current physician disciplinary system. There were as many or more cases referred to in the BGA/*Sun-Times* investigations that involved physicians who were not properly licensed, and other personnel performing services specifically prohibited by State pro-

fessional licensing laws which have not been acted on. Unlicensed personnel passed medication, took medical histories, assisted in surgery, gave anesthesia and took vital signs. Physicians convicted of Medicaid fraud in connection with their abortion clinics still have their licenses.

The Department has the clear authority to crack down on abusive and fraudulent practitioners. Its performance was supposed to have improved substantially with the enactment of special legislation in 79th General Assembly that created a new Medical Disciplinary Board with strong investigative powers and capabilities devoted specifically to the tough regulation of physicians. The powers and duties of this Board, and its employees, have not been fully realized however. An impasse between the Board, its Medical Coordinator and the Director of the Department of Registration & Education have prevented this legislation from achieving its full promise. The Board has not been kept fully informed of complaints filed about cases of suspected licensure law violations, nor has it been able to independently instigate investigations of cases referred to it by individuals and organizations outside of the Department. This bureaucratic infighting is counterproductive and can only serve to hamper the overall effort of regulation.

If the Board is encumbering the Director of the Department of Registration & Education it should be abolished immediately. If it has a meaningful role to play in the conduct of independent investigations and the coordination of a strong, dedicated program in the regulation of physicians, its powers and duties should be expanded so that its full potential is realized.

The Director of the Department of R&E has indicated that an aggressive investigation is being conducted of the abortion clinics and professional medical personnel involved. This effort will hopefully result in the discipline of many of the people who were abusing patients. The fact that the Department did not realize that these abuses were occurring until the facts were disclosed in the newspaper should serve notice that its program of regulation is as faulty as that of the Department of Public Health. The Department should re-evaluate its methods and procedures to crackdown on the clinic operators to the fullest extent possible.

21) IMPROVE LINKAGE BETWEEN DEPARTMENT OF R&E AND ITS MEDICAL DISCIPLINARY BOARD. REQUIRE REPORTING OF CERTAIN COMPLAINTS

The Medical Practice Act appears to provide a significant degree of autonomy for the Medical Disciplinary Board in the receipt and conduct of investigations of complaints in relation to physician licensure suspensions or revocations. The law expressly indicates a concurrent power with the Department to initiate reviews and make recommendations for discipline, but in practice it rarely exercises this authority. Practically all complaints are examined by the Medical Coordinator. The Board is not informed about all complaints, nor their disposition, even though the Medical Coordinator under the law, serves at the "... will of the Board...." Unless a case is specifically referred to it by the Coordinator or the Director of the Department for review and recommendation, there is no continuous communication about the findings of a preliminary examination of a complaint or the grounds upon which it is pursued, or not. In practice, the Board does not act with much independence or autonomy except in the conduct of the advisory hearing where the specific issue of the licensure suspension or revocation is to be contested.

The issue of contention between the Board and the Department, therefore, involves an interpretation of the Medical Practice Act which appears to allow the Department to bypass or ignore the Board in the initial stages of any investigation or review of a complaint. A matter may eventually be referred for hearing, but only in those instances where specific charges

are developed and the Department is prepared to seek disciplinary action. The Board's function is simply one of reviewing the specific accusations and evidence in the development of a recommendation to suspend or revoke a physician license. The Department is obviously concerned about the Board interfering with investigations that could complicate a successful disciplinary action. Since the Board is composed primarily of physicians (5 are MD's, 1 is an MD with a specialty in Osteopathy and 1 is a Chiropractor) there is a very real concern that the Board will be protective of its peers and not act aggressively to effect tough discipline.

As a minimum step, the Board ought to have the authority to review all complaints which are dismissed by the Department and not investigated. The Board ought to have the opportunity to determine for itself if a complaint was substantive and worthy of review, as a cross-check on the Department. The Board also ought to be informed of any complaints which are investigated and dismissed prior to hearing.

An additional consideration may be a revision of the membership of the Board to include some public members, so that the concern about peer pressure and control is moderated. As the Director of the Department of R&E points out, a government agency responsible for professional licensure cannot be effective if it is controlled by the regulated professionals.

22) REPEAL & AMEND EXISTING STATUTES TO CLARIFY CURRENT ABORTION LAW

A Federal district court opinion (*Wynn v. Scott*, 449 F. Supp. 1302, 1978) declared various aspects of the Abortion Law of 1975 unconstitutional. Particular provisions relating to parental consent were specifically struck down. The provisions of current law should reflect these rulings as accurately as possible. The specific Sections referred to in that opinion and related laws (i.e. the IL Abortion Parental Consent Act

of 1977) should either be amended or repealed as necessary.

Additionally, the Abortion Law of 1973 remains on the books even after the Abortion Law of 1975 was enacted. The 1973 Act is duplicative and effectively obsolete. As a "housecleaning" measure, it should be repealed.

CORRECT AN OBVIOUS DISCREPANCY IN THE ABORTION LAW OF 1975

Aside from the many issues struck down by the Courts in the Abortion Law of 1975, (Ch. 38, pars. 81-21 through 81-35, *IRS 1977*), a distinct problem remains in Sections 10 and 11 of that Act with respect to the reporting of data to the Department of Public Health. In part, the problem derives from a definition in Section 3 which provides that a "Criminal Abortion" is any technique performed by a physician *except when done* "... *in conformity with this Act* ..." This definition would clearly indicate that if the physician fails to submit the (regulatory) reports required in Sections 10, or any aspect of those reports, to the Department of Public Health then s/he may be found guilty of a criminal abortion. Failure to submit the reports is, therefore, not only punishable under Section 11 as a Class 2 felony, but it would also be punishable as a Class B Misdemeanor.

The statistical or regulatory reports to be filed should be referenced in the Ambulatory Surgical Treatment Center Licensing Act, since that statute generally delineates the responsibilities of the Department of Public Health in its regulation of facilities where abortions must be performed. The filing of the reports should not be confused with the actual performance of the abortion. A criminal investigation should not be confused with the facility or professional regulation. Additionally, the IDPH should have the capability of utilizing any reports filed by physicians in relation to abortions, and the Abortion Law of 1975

currently limits this function—as referenced in Recommendation #4. Proper referencing of the reporting requirements in the Licensure Act should resolve this problem.

23) ENCOURAGE ESTABLISHED, REPUTABLE MEDICAL VENDORS TO PROVIDE NEEDED SERVICES

Abortion mills on Michigan Avenue can thrive to a large extent because many physicians and hospitals throughout the State have elected not to provide the medical services that thousands of women are seeking annually. For this reason these established and reputable providers must bear some of the responsibility for the tragedies that have occurred as reported in the recent news stories.

Public agencies and facilities, including State University medical institutions, have an obligation to respond to the interests and needs of women seeking abortions. Private organizations, like the State Medical Society and the IL Hospital Association, and private facilities or other medical vendors also have a responsibility to protect the health and safety of the general citizenry by insuring the availability of competent reputable abortion services. There should be no further "ducking" or "shirking" of these medical responsibilities so long as it means injury and death to women who must otherwise turn to a "greedy profiteer" for care.

State law permits physicians, hospitals, ambulatory surgical treatment centers or their employees to refuse to perform abortions for reasons of conscience and this has effectively caused some areas of the State to be without any services at all. This is often done without regard to the public or private nature of a facility.

As an example of the existing accessibility problem, there are no clinics or hospitals in the City of Springfield that will provide abortions in the 1st Trimester. Physicians of this area generally do not take such

cases because of the conditions of their affiliation agreements with the local hospitals. Residents of Springfield seeking abortions are normally referred to facilities and services in St. Louis, Missouri.

All responsible officials and medical providers should convene and resolve the issue of *access* as soon as possible. Services should be available in all areas of the State.

Some physicians are being discriminated against for performing these types of services. Many are being subjected to severe peer pressure and deterred from offering or providing this care. The segregation of this particular medical service and the discriminatory regulation of the facilities and providers deters too many reputable and qualified practitioners from serving patients-in-need.

Vendors of medical care should not discriminate against patients or peers for either seeking to obtain, or for providing abortion services, so long as there is no legal prohibition on the rendering of this care. It is a hardship on the patient and, more importantly, an unfortunate incentive to the unscrupulous abortion clinic owners and operators that this service is not more generally available to women throughout the State.

There are clearly differences in costs between services at ambulatory surgical treatment centers and hospitals. This may be reflective of qualitative differences, but it also indicates the relatively higher cost between acute, inpatient care and outpatient services that usually separate a hospital from a free-standing clinic. Rate structures of hospitals may also serve as effective deterrents to the "abortion traffic"—some facilities would actually prefer that women utilize alternatives and not clog their current workload.

APPELLEE'S

BRIEF

No. 88-790

Supreme Court, U.S.
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In The
Supreme Court of the United States
October Term, 1989

BERNARD J. TURNOCK, M.D., M.P.H.,
Director of the Illinois Department
of Public Health, *et al.*,

Appellants,

v.

RICHARD M. RAGSDALE, M.D., *et al.*,

Appellees.

On Appeal From the United States
Court of Appeals For the Seventh Circuit

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QUESTIONS PRESENTED

1. Whether defendants erroneously ask this Court for premature review of the Court of Appeals' affirmance of a preliminary injunction.

2. Whether the Court of Appeals properly affirmed a preliminary injunction prohibiting the enforcement of an Illinois statutory scheme, as applied to early abortions, because the burdensome scheme restricted the performance of early abortions to the functional equivalent of small hospitals without any medical justification.

PARTIES

The plaintiffs in the District Court, and the appellees in the Court of Appeals and before this Court, are: Richard M. Ragsdale, M.D., individually and on behalf of physicians presently performing or wishing to perform abortions in the State of Illinois and on behalf of their women patients desiring abortions; Margaret Moe, a registered nurse; Sarah Roe, a woman who needed an abortion for medical reasons; and Jane Doe, an indigent woman; Moe, Roe and Doe appear individually and on behalf of all Illinois women who desire abortions; and the Northern Illinois Women's Center.[1]

The defendants in the district court were: Neil Hartigan, Attorney General of Illinois; Bernard Turnock, Director of the Illinois Department of Public Health; Gary L. Clayton, Director of the Illinois Department of Registration and Education; and Richard M. Daley, State's Attorney of Cook County, Illinois, individually and as a defendant class representative of all state's attorneys in the State of Illinois.

In this Court, defendants Hartigan and Turnock filed a notice of appeal, as did Stephen F. Selke, Director of the Illinois Department of Professional Regulation and the successor in public office to Gary L. Clayton. Defendant Daley did not file a notice of appeal in this Court or in the Court of Appeals.

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[1] Pursuant to Supreme Court Rule 28.1, plaintiffs state that the Northern Illinois Women's Center is a medical corporation wholly owned by Richard M. Ragsdale, M.D., and has no parent, no subsidiaries and no affiliate corporations.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
PARTIES	ii
TABLE OF CONTENTS	iii
TABLE OF CASES AND OTHER AUTHORITIES	vii
OPINIONS BELOW	1
CONSTITUTIONAL, STATUTORY AND REGULATORY PROVISIONS	1
JURISDICTION	1
STATEMENT OF THE CASE	3
A. The Three Challenged Statutes, As An Interlocking Whole, Obstruct The Ability Of Women To Secure Early Abortions In Illinois By Restricting Such Abortions To Small Hospitals . .	2
1. Plaintiffs sought a preliminary injunction when enforcement of this scheme threatened closure of the only abortion facility in northwestern Illinois.	4

2. The District Court entered a preliminary injunction, affirmed by the Court of Appeals, after finding that this scheme burdened the rights of women without furthering the safety of the abortion procedure 5

B. Early Abortions Are Among The Most Common And Safe Surgical Procedures 8

C. The Physical Plant Regulations, At The Core Of Plaintiffs' Challenge, Mirror Hospital Regulations 12

D. These Statutes Burden A Woman's Effectuation Of Her Decision To Have An Abortion 16

E. Defendants Introduced No Evidence To Support Their Claims That The Burdens Imposed By These Statutes Further Any Legitimate Governmental Purpose 21

SUMMARY OF THE ARGUMENT 23

ARGUMENT 25

I. THIS COURT LACKS MANDATORY JURISDICTION AND SHOULD NOT EXERCISE ITS DISCRETIONARY JURISDICTION TO REVIEW THE COURT OF APPEALS' AFFIRMANCE OF THE PRELIMINARY INJUNCTION. 31

II. THE SEVENTH CIRCUIT APPROPRIATELY AFFIRMED THE PRELIMINARY INJUNCTION BECAUSE THE CHALLENGED SCHEME SIGNIFICANTLY BURDENS, WITHOUT ANY JUSTIFICATION, A WOMAN'S RIGHT TO MAKE DECISIONS ABOUT CHILDBEARING. 27

A. The Constitution Protects Against Unwarranted Governmental Interference With A Woman's Fundamental Right To Make Decisions About Contraception and Abortion. 28

B. Regulation That Restricts The Right To Have An Abortion In The Earliest Stages Of Pregnancy Has Been Upheld Only If It In Fact Furthers The Safety Of The Medical Procedure 30

C. The District Court Finding That This Scheme Significantly Restricts Early Abortions Is Not Clearly Erroneous. 32

D. Defendants Fail To Justify This Burdensome Statutory Scheme With Any Evidence To Show The Furtherance Of A Legitimate, Let Alone Compelling, Governmental Interest 37

E. Defendants' Claim That A Rational Basis Standard Applies Because The Scheme Is Abortion-Neutral Is Baseless In Law And Fact 44

III. THE SEVENTH CIRCUIT APPROPRIATELY AFFIRMED THE DISTRICT COURT'S PRELIMINARY INJUNCTION OF THE CHALLENGED SCHEME IN ITS APPLICATION AS AN INTEGRATED WHOLE TO EARLY ABORTION PROCEDURES 46

CONCLUSION. 50

TABLE OF CASES AND OTHER AUTHORITIES

TABLE OF AUTHORITIES

CASES *Pages*

Arcara v. Cloud Books, Inc. 478 U.S. 697 (1986). 46

Aptheker v. Secretary of State, 378 U.S. 500 (1964) 28, 38

Ashwander v. Tennessee Valley Authority, 297 U.S. 248 (1936). 23, 27

Baird v. Department of Public Health, 599 F.2d 1098 (1st. Cir. 1979) 36

Bates v. Little Rock, 361 U.S. 516 (1960) . . 30, 35

Bibb v. Navajo Freight Lines, Inc., 359 U.S. 520 (1959) 42

Birth Control Centers, Inc. v. Reizen, 743 F.2d 352 (6th Cir. 1984) 36

Bolger v. Young Drug, 463 U.S. 60 (1983) . 43

Buck v. Bell, 274 U.S. 200 (1927). 29

C.I.O. v. McAdory, 325 U.S. 472 (1945) . . 34

	Pages
Carey v. Population Services International, 431 U.S. 678 (1977)	29, 35, 38
Carter v. Carter Coal Co., 298 U.S. 238 (1936)	25, 48
City of Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416 (1983)	passim
City of Cleburne v. Cleburne Living Center, Inc. 473 U.S. 432 (1985)	24, 46
City of Mesquite v. Aladdin's Castle, Inc., 455 U.S. 283 (1982)	34
City of Renton v. Playtime Theatres, Inc., 475 U.S. 41 (1986)	46
Colautti v. Franklin, 439 U.S. 379 (1979)	31
Connecticut v. Menillo, 423 U.S. 9 (1975)	32
Dean Milk Co. v. Madison, 340 U.S. 349 (1951)	43
Doe v. Bolton, 410 U.S. 179 (1973)	6, 38
Eisenstadt v. Baird, 406 U.S. 438 (1972)	28, 29

	Pages
Friendship Medical Center, Ltd. v. Chicago Bd. of Health, 505 F.2d 1141 (7th Cir. 1974), *cert. denied*, 420 U.S. 955 (1975)	36
Gibson v. Florida Legislative Investigation Committee, 372 U.S. 539 (1963)	38
Green v. Mansour, 474 U.S. 64 (1985)	34
Griswold v. Connecticut, 381 U.S. 479 (1965)	23, 28, 29
Harris v. McRae, 448 U.S. 297 (1980)	39, 40
Hedd SurgiCenter v. Turnock, 711 F. Supp. 439 (N.D. Ill. 1989), *appeal docketed*, No. 89-1977 (7th Cir. May 10, 1989)	7, 26
Hill v. Wallace, 259 U.S. 44 (1922)	49
Hodgson v. Lawson, No. 4-74-155 (D. Minn. Mar. 7, 1977)	36
Hodgson v. Lawson, 542 F.2d 1350 (8th Cir. 1976) (*per curiam*)	36
In re A.C., 533 A.2d 611 (Sup. Ct. App. 1987), *vacated*, 539 A.2d 203 (D.C. Ct. App. 1988)	29

	Pages
Kassel v. Consolidated Freightways, 450 U.S. 662 (1981)	42, 43
Kramer v. Union Free School District, 395 U.S. 621 (1969)	30
Loving v. Virginia, 388 U.S. 1 (1967)	28
Maher v. Roe, 432 U.S. 464 (1977)	40
Mahoning Women's Center v. Hunter, 610 F.2d 456 (6th Cir. 1979) *vacated on other grounds*, 477 U.S. 918 (1979)	36
Martin v. Struthers, 319 U.S. 141 (1943)	45
McElroy v. United States, 361 U.S. 281 (1960)	47
Pike v. Bruce Church, 397 U.S. 137 (1970).	43
Planned Parenthood Association v. Ashcroft, 462 U.S. 476 (1983)	32, 39, 40
Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976)	31, 36
Poelker v. Doe, 432 U.S. 519 (1977)	40
Ragsdale v. Turnock, 625 F. Supp. 1212 (N.D. Ill. 1985)	*passim*

	Pages
Ragsdale v. Turnock, 841 F.2d 1358 (7th Cir. 1988)	*passim*
Raymond Motor Transportation Inc. v. Rice, 434 U.S. 429 (1978)	42, 44
Roe v. Wade, 410 U.S. 113 (1973)	*passim*
Schware v. Board of Bar Examiners, 353 U.S. 232 (1957)	46
Shapiro v. Thompson, 394 U.S. 618 (1969)	30
Sherbert v. Verner, 374 U.S. 398 (1963)	30
Skinner v. Oklahoma, 316 U.S. 535 (1949)	28
Sloan v. Lemon, 413 U.S. 812 (1973)	25, 48
Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747 (1986)	*passim*
Turner v. Safley, 482 U.S. 78 (1987)	28
Turnock v. Ragsdale, 109 S.Ct. 3239 (1989)	2
United States v. O'Brien, 391 U.S. 367 (1968)	24, 45

	Pages
Ward v. Rock Against Racism, ____ U.S. ___, 109 S.Ct. 2746 (1989)	45
Webster v. Reproductive Health Services, ____ U.S. ____, 109 S.Ct. 3040 (1989)	*passim*
Wisconsin v. Yoder, 406 U.S. 205 (1972) .	45
Zobel v. Williams, 457 U.S. 55 (1982)	46

CONSTITUTIONAL PROVISIONS

U.S. Const. Amend. I	1
U.S. Const. Amend. IV	1
U.S. Const. Amend. V	1
U.S. Const. Amend. IX	1
U.S. Const. Amend. XIV	1

STATUTES

28 U.S.C. § 2201	1
28 U.S.C. § 2202	1
28 U.S.C. § 1254(2)	1, 23, 25
42 U.S.C. § 1983	1

	Pages
Ambulatory Surgical Treatment Center Act, Ill. Rev. Stat. ch. 111-1/2, par. 157-8.1 *et seq*.	*passim*
Health Facilities Planning Act, Ill. Rev. Stat. ch. 111-1/2, par. 1151 *et seq*.	*passim*
Hospital Licensing Act, Ill. Rev. Stat. ch. 111-1/2, par. 142-57	*passim*
Medical Practice Act, Ill. Rev. Stat. ch. 111, par. 4400-22 *et seq*.	*passim*

REGULATIONS

Hospital and Ambulatory Care Facilities Regulation, 77 Ill. Admin. Code, Ch. 1, Subpart b, parts 205 and 250	*passim*

TREATISES

Hern, *Abortion Practice* (1984)	8

	Pages
MISCELLANEOUS	
American College of Obstetricians and Gynecologists (ACOG) Standards for Obstetric-Gynecologic Services (6th ed. 1985)	9, 10, 11
American College of Obstetricians and Gynecologists (ACOG) Standards for Obstetric-Gynecologic Services (7th ed. 1989)	10
Riffer, *Can Surgicenters Stand Alone?*, Hospitals 44 (July 20, 1986)	17
Tatalovich & Daynes, *The Geographic Distribution of U.S. Hospitals with Abortion Facilities*, 21 Fam. Plan. Persp. 81 (1989)	11, 37
Illinois Register, Oct. 13, 1989	33
Report to Illinois House Human Resources Committee (1978)	36, 37, 41

OPINIONS BELOW

(See Defendants' Brief)

CONSTITUTIONAL, STATUTORY AND REGULATORY PROVISIONS

(See Defendants' Brief)

JURISDICTION

Plaintiffs sought relief under 28 U.S.C. §§ 2201 and 2202 and 42 U.S.C. § 1983, against enforcement of portions of three Illinois laws. (Jt. App. 3-24.) After an expedited hearing, the District Court entered a preliminary injunction. *Ragsdale v. Turnock*, 625 F. Supp. 1212, 1215 (N.D. Ill. 1985), App. 109-11, 114.[2] The Court of Appeals affirmed all but a portion of the preliminary injunction. *Ragsdale v. Turnock*, 841 F.2d at 1358, 1376 (7th Cir. 1988), App. 33.

Defendants appealed under 28 U.S.C. § 1254(2), prematurely seeking review of the affirmance of the preliminary injunction. (Juris. St. 2.) This Court

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[2] References to defendants' Jurisdictional Statement appear as "Juris. St." References to the appendix accompanying the Juris. St. appear as "App." This appendix contains the slip opinion of the Court of Appeals at 1-80, with amendments to that opinion at 103-04. The full and correct opinion is reported at 841 F.2d 1358. References to Brief of Defendants/Appellants appear as "Def. Br." References to the Joint Appendix are to "Jt. App.," with other references to the trial transcript appearing as "Tr." or "Dep.," and references to Brief of Defendants-Appellants filed in the Court of Appeals as "Def. Br. Ct. App."

postponed further consideration of the question of jurisdiction until the hearing of the case on the merits. *Turnock v. Ragsdale*, 109 S.Ct. 3239 (1989).

STATEMENT OF THE CASE

A. The Three Challenged Statutes, As An Interlocking Whole, Obstruct The Ability Of Women To Secure Early Abortions In Illinois By Restricting Such Abortions To Small Hospitals.

The Illinois General Assembly enacted the challenged statutory scheme shortly after this Court's decision in *Roe v. Wade*, 410 U.S. 113 (1973). The statutes explicitly single out all early abortions for special restrictions not applicable to any other medical procedure. The legislative history underscores the General Assembly's design to restrict all early abortions to either hospitals or their functional equivalent — ambulatory surgical treatment centers ("ASTC"), as defined and licensed under this scheme. *See* 841 F.2d at 1369, App. 21.

The first link in the statutory scheme, the Ambulatory Surgical Treatment Center Act ("ASTC Act"), Ill. Rev. Stat. ch. 111-1/2, ¶ 157-8.1 *et seq.*, App. 149-65, requires an ASTC license for any facility in which an abortion is performed. An ASTC is defined as:

> any institution, place or building devoted *primarily* to the maintenance and operation of facilities for the performance of surgical procedures *or any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose. . . .*

Ill. Rev. Stat. ch. 111-1/2, ¶ 157-8.3(A), App. 149-50 (emphasis added). The ASTC Act expressly exempts from licensure physicians' offices in which outpatient surgical procedures with higher rates of morbidity and mortality than abortion are performed. *See, e.g.*, Ill. Rev. Stat. ch. 111-1/2, ¶ 157-8.3(A)(5), App. 150; Jt. App. 181. Deviation from the ASTC Act requirements results in high penalties. *See* Ill. Rev. Stat. ch. 111-1/2, ¶ 157-8.12, App. 163 (performing abortion in unlicensed facility punishable by a $10,000 per day fine; violating any other provision of ASTC Act subjects "violator" to additional $10,000 fine).

Section 22 of the Medical Practice Act ("MPA"), Ill. Rev. Stat. ch. 111, ¶ 4400-22, App. 193-202, forging the second link in defendants' scheme, directs the Department of Professional Regulation to revoke or suspend the license of any physician who performs a single abortion outside of a hospital or a licensed ASTC.

The third statutory link, the Health Facilities Planning Act ("HFPA"), Ill. Rev. Stat. ch. 111-1/2, ¶ 1151 *et seq.*, App. 166-92, requires ASTCs, like hospitals, to obtain certificates of need ("CON") prior to any construction, renovation or relocation. Providers seeking ASTC licenses must submit to hearings on the "need" for abortion services in a government-created forum. 625 F. Supp. at 1226, App. 130-32; 841 F.2d at 1375, App. 32.

1. Plaintiffs sought a preliminary injunction when enforcement of this scheme threatened closure of the only abortion facility in northwestern Illinois.

In 1985, Dr. Richard Ragsdale, the only abortion provider in northwestern Illinois, lost his lease and was faced with terminating his medical practice because he could not rent a facility in Rockford — the second-largest metropolitan area in Illinois — that would comply with challenged laws. 625 F. Supp. at 1218, App. 118.

Plaintiff Margaret Moe, a registered nurse who administers two medical facilities and refers patients to Dr. Ragsdale, joined the suit because her patients would be harmed by the closure of Dr. Ragsdale's practice. Ms. Moe also wanted to accommodate her patients' requests for early abortion services through the licensed physicians who practiced with her. She was unable to do so because her facilities did not comply with the physical plant, structural and administrative requirements of the challenged scheme. *Id.* at 1218, App. 118-19.

Plaintiff Jane Doe, a married woman and the mother of several children, depended upon Dr. Ragsdale for abortion services. Several physicians in Rockford had advised her that uterine fibroids associated with her pregnancy "posed a serious risk to her health," but, despite her "severe pain and emotional trauma," had refused Mrs. Doe an abortion. *Id.* at 1218-19, App. 119. Dr. Ragsdale was the only Rockford physician who would provide Mrs. Doe the medical care she needed. *Id.* at 1219, App. 119. Future pregnancies would present the same health risks; Mrs. Doe

joined the suit. (Jt. App. 7-8.) Sarah Roe, an indigent woman and a mother of two, would not have been able to have an abortion but for Dr. Ragsdale's policy of charging only a minimal fee to women in such circumstances. *See* 625 F. Supp. at 1218, App. 119.

Threatened with forced closure of Dr. Ragsdale's practice, plaintiffs sought a preliminary injunction. Plaintiffs' challenge focused on the cumulative impact of the regulatory scheme as a whole, with a special emphasis on the scheme's most burdensome provisions: physical plant regulations that mandate construction of a small hospital; regulations that interfere with the physician-patient relationship; and the CON requirement. Many of these restrictions actually harm the woman's health.[3]

2. The District Court entered a preliminary injunction, affirmed by the Court of Appeals, after finding that this scheme burdened the rights of women without furthering the safety of the abortion procedure.

After a five day evidentiary hearing, the District Court found that "the challenged statutes and regulations do place a very real and a very heavy burden on the right of a woman to

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[3] Although plaintiffs did not object to certain individual provisions which, in isolation, might "pass constitutional muster," 841 F.2d at 1372 n.11, App. 25-26 n.11, defendants' inflexible enforcement and the cumulatively burdensome nature of the licensing scheme left plaintiffs no choice but to challenge the scheme as an integrated whole.

decide to terminate her pregnancy." 625 F. Supp. at 1227, App. 132. The "scheme, as written and as enforced, has the effect of raising the cost and limiting the availability of abortions" by restricting all early abortions in Illinois to the functional equivalent of a small hospital." 625 F. Supp. at 1225, App. 129. Because the scheme actually undermines, rather than promotes, defendants' asserted interest in protecting women's health, the District Court found no "compelling, or even . . . rational, basis for the statutory and regulatory scheme." *Id.* at 1230, App. 138. The Court thus concluded that plaintiffs had satisfied the criteria for a preliminary injunction and granted class-wide relief, while noting specifically the need to prevent the imminent deprivation of early abortion services in northwestern Illinois. *Id.* at 1215, 1219-22, 1224-31, App. 114, 119-25, 128-39.[4]

The injunction did not, as defendants contend, "emasculate" the State's general licensing authority. (Juris. St. 21.) Left unchallenged and hence undisturbed, were the professional censure and licensing provisions of the MPA, applicable to all physicians in the state. *Compare Doe v. Bolton*, 410 U.S. 179, 200 (1973). This broad regulatory authority, the State's primary means of assuring competent medical care, now encompasses the power, among other

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[4] The District Court concluded that plaintiffs had established a strong likelihood of success on the merits of their challenge under the privacy doctrine. 625 F. Supp. at 1228-30, App. 134-38. Plaintiffs also asserted an equal protection challenge, *id.* at 1214, 1224, App. 112, 128-29, which the District Court did not reach. *Id.* On remand for permanent injunction proceedings, plaintiffs intend to submit proof on their equal protection challenge.

things, to inspect, under appropriate circumstances, any facility in which physicians practice — even those exclusively devoted to the provision of early abortion services. Ill. Rev. Stat. ch. 111, ¶ 1258.270.

In drafting the injunction, the District Court was careful to restrict enforcement of the laws only to the extent the provider "offers or performs, or desires to offer or perform first, and/or early second trimester abortions or other abortion-related gynecological procedures, such as a dilation and curettage." (App. 110.) Consonant with the limits of plaintiffs' challenge, the Court expressly preserved the State's authority to enforce its regulatory scheme to non-abortion medical procedures, even when abortion and non-abortion procedures are performed in the same facility. (App. 110-11.) *See also Hedd SurgiCenter v. Turnock*, 711 F. Supp. 439 (N.D. Ill. 1989), *appeal docketed*, No. 89-1977 (7th Cir. May 10, 1989) (preliminary injunction in *Ragsdale* does not bar State from enforcing ASTC Act against facilities which perform surgical procedures in addition to early abortions).

The Court of Appeals affirmed the preliminary injunction, concluding that the District Court was not clearly erroneous in finding that the tripartite regulatory scheme burdened the rights of women seeking early abortions and that defendants had failed to supply any evidence that such regulation furthered the safety of these procedures. 841 F.2d at 1371-75, App. 23-32. The Court of Appeals also affirmed the District Court's findings that the challenged scheme actually proved harmful for some women seeking abortions. *Id.* at 1368, 1373-74, App. 18, 27-28.

B. Early Abortions Are Among The Most Common And Safe Surgical Procedures.

All three physicians who testified at trial, including defendants' expert, agreed that an early abortion is a "minor" procedure which is "very safe."[5] (Jt. App. 76-77, 181-84; Barton, Dep. 95-96, Jt. App. 282.).[6] The risk of mortality from abortion is no greater than the risk from an intermuscular injection of penicillin. Brief of Planned Parenthood Federation of America, Inc. and the National Abortion Federation as *Amici Curiae* Supporting Appellees

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5 Dr. Warren Hern, who testified on behalf of plaintiffs, wrote the textbook *Abortion Practice*, which is used at many medical schools. (Tr. 227-31.) Dr. Hern, who practices in Colorado, was accepted by the District Court as an expert in the areas of abortion services and abortion epidemiology. (Tr. 233)

Dr. Ragsdale also was found to be as an expert in abortion services (Tr. 44). He is a skilled physician to whom even defendants' medical expert witnesses would refer patients. (Ramsey Dep. 41-42, App. 307; *see also* Barton Dep. at 66.)

Dr. Barton, who testified for defendants, lacked significant experience in performing abortions. As the Court of Appeals noted, "the district court properly accorded his testimony little weight." 841 F.2d at 1374 n.12, App. 30 n.12.

6 Defendants misconstrue Dr. Hern's testimony when they claim that he had concluded, during cross-examination based upon statements in his book, that early abortions are hazardous. *See* Def. Br. 10-11. In his book, Dr. Hern lamented that medical schools devote too little attention to assuring that new physicians receive the necessary training to safely perform abortions, which is essential if women are to be offered complete gynecological care. Hern, *Abortion Practice* at 103-04 (1984) (Plaintiffs' Exhibit 12).

("PPFA/NAF Br.") 16. A simple tonsillectomy is at least twice as dangerous as an abortion; a woman's risk of death from giving birth is up to 25 times greater than the risk of death from an early abortion. (Jt. App. 183-84.)[7]

"The single most important factor in [the] safety of the abortion procedure is the skill and experience of the operating physician." (Jt. App. 183-84, 82-83, 285-86.) Nothing in the challenged provisions governs these factors. (Jt. App. 311-13.)

As the District Court found, the American College of Obstetricians and Gynecologists ("ACOG") recommends that early abortions be performed in physicians' offices and clinics, 625 F. Supp. at 1229 n.21, Jt. App. 135 n.21,[8] as

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7 Contrary to suggestions made by defendants' *amici*, abortion is among the safest of all surgical procedures. It is far safer for the woman than is carrying a pregnancy to term. Approximately 60% of women who carry to term are treated for complications; 30% of women who carry to term are treated for major complications. PPFA/NAF Br. at 5 n.10 and sources cited therein. In sharp contrast, the most recent abortion statistics indicate a complication rate of less than 1% for abortions performed within the first 14 weeks and only 3.3 complications per 1,000 procedures, regardless of the gestational age of pregnancy. *Id.* As defendants concede, Def. Br. 9, of the approximately 40,000 women for whom Dr. Ragsdale has provided abortions, only 1.3%-2% experienced minor complications; major complications occurred in approximately .0006% of these procedures.

8 *See also* ACOG Standards for Obstetric-Gynecologic Services 60 (6th ed. 1985) ("ACOG Standards"), (Jt. App. 49-63); Brief of the American College of Obstetricians and Gynecologists, *et al.*, as *Amici Curiae* in support of appellees ("ACOG Brief"). In its Standards, ACOG states that "[p]rocedures commonly performed in a physician's office or in an outpatient clinic include, but are not limited to . . .

(Footnote continued on the following page)

opposed to freestanding or hospital-based ambulatory surgical facilities such as licensed ASTCs. (ACOG Standards at Jt. App. 50-52; *see also* ACOG Brief at 9.)[9] ACOG recommends that freestanding and hospital-based ambulatory surgical facilities meet hospital-like standards, because it is anticipated that procedures much more complicated than early abortions will be performed there. (ACOG Standards, Jt. App. 52-53.) Defendants "mislead [ ] the Court when [they] impl[y] that ACOG's Standards

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[a]bortion, uncomplicated, up to 14 weeks from last menstrual period . . . ." (Jt. App. 52.) In a separate section of its Standards devoted exclusively to abortion, ACOG again approves the performance of early abortions — up to 14 weeks — in a physician's office; and approves the performance of later abortions — up to 18 weeks — in a hospital-based or freestanding surgical facility. (Jt. App. 54-55.) The Seventh Edition of the ACOG Standards, issued in 1989, continues to maintain these guidelines. (Pl. App. B.)

9 As ACOG and other medical amici explain:

> Abortions may be safely performed in any of four settings: a doctor's office, an outpatient clinic, a freestanding ambulatory surgical facility or a hospital. . . . For uncomplicated abortions performed up to the fourteenth week, which represent over 90% of all abortions performed in this country, a physician's office or clinic *is the most appropriate setting*. . . . [Early abortions, which involve] no incision and require[ ] only local anesthesia . . . [are] routinely and efficiently performed with least emotional trauma for patients in an office or clinic.

(ACOG Brief at 9 (citation and footnotes omitted).)

endorse the use of ASTCs for [early] abortion services." ACOG Br. at 9 n.24.[10]

Dr. Ragsdale performs early abortions in his clinic using the safest available method, the suction curettage technique, under local anesthesia. (Tr. 44, 162; Jt. App. 181.) The suction curettage involves no incisions in the woman's body (Jt. App. 181), and does not require general anesthesia, which would otherwise increase the risk of the procedure. (Jt. App. 180-81.) (*See* ACOG Br. 8.)

The suction curettage procedure that Dr. Ragsdale uses is quite similar to a diagnostic dilation and curettage ("D&C"), routinely performed in physicians' offices to test for cancer. (Jt. App. 190-91; Tr. 59-60.) Neither Illinois nor any other state specially regulates D&Cs or other similar gynecological procedures. (Jt. App. 225.)

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10 Nationwide, outpatient clinics like Dr. Ragsdale's have become "the optimal means for providing easily accessible, relatively inexpensive terminations of pregnancy." Tatalovich & Daynes, *The Geographic Distribution of U.S. Hospitals with Abortion Facilities*, 21 Fam. Plan. Persp. 81 (1989). As set forth in PPFA/NAF Br. at 4, in 1985, the last year for which data is available, 83% of all abortions were performed in clinics.

Improved technology, and specialization have resulted in clinic procedures becoming as safe, if not safer, than in-hospital procedures. *Id. See also* Forrest, *Delivery of Abortion Care in the United States* 175 (Landy & Ratnam ed. 1986). Between 1973, when a majority of abortions were performed in hospitals, and 1985, when a majority of abortions were performed in clinics, abortion mortality rates decreased dramatically — from 4.1 deaths in 1973 to 0.5 in 1985 per 100,000 procedures. PPFA/NAF Br. 14, (citing Center for Disease Control, Abortion Statistics, 1984-85).

C. The Physical Plant Regulations, At The Core Of Plaintiffs' Challenge, Mirror Hospital Regulations.

Under the express terms of the scheme, any facility in which an abortion is performed must comply fully with complex building requirements which "cause abortion providers to incur great construction and renovation costs" because they must build "the functional equivalent of small hospitals." 625 F. Supp. at 1216-17, App. 115, 117. Defendants characterize the physical plant requirements as "standard" for abortion facilities. (Def. Br. 19.) They are not.

The room and corridor size requirements, the heating, ventilation, and air conditioning requirements, the diagnostic facilities and the details and finishes mandated by the ASTC requirements are "standard" only for inpatient facilities such as hospitals. (Jt. App. 232-35.) *See also* Pl. App. C (comparison of hospital regulations and ASTC regulations). They are not "standard" for outpatient facilities and doctor's offices (*id.*) in which ACOG recommends that early abortions be performed — and where most early abortions, in fact, are performed. Among other things, an office environment is more comfortable for the patient and helps ensure her privacy. (Jt. App. 75.)[11]

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11 A survey done of 254 Planned Parenthood and National Abortion Federation affiliates and members who collectively perform approximately 35% of the 1.6 million abortions performed annually indicates that "98% of the responding clinics would face the prospect of being immediately closed for noncompliance." (PPFA/NAF Br. 18-19.)

Subpart I of the ASTC regulations, for example, demands that an ASTC contain rooms with dimensions similar to those required of a hospital, including: (1) at least one procedure room with 250 square feet; (2) any other procedure room with at least 120 square feet each; (3) recovery rooms with at least 100 square feet; and (4) examination rooms with at least 80 square feet. (Subpart I, § 205.1360(a)(b)(c), App. 231-33; Linder, Dep. 70-72; Jt. App. 109-11.) These room dimensions were designed to accommodate major surgical procedures performed under general anesthesia (Linder, Dep. 48), such as hernia repairs and rhinoplasty surgeries (Tr. 764), as opposed to minor procedures such as early abortions. (Jt. App. 282.)

Though the procedure rooms in Dr. Ragsdale's original facility, licensed under the ASTC Act, complied with an earlier version of the ASTC requirements, they did not meet the 250 square foot requirement. (Jt. App. 110-11.) Although Dr. Ragsdale had performed safe abortions for 12 years in that facility, Illinois Department of Public Health ("IDPH") regulators warned Dr. Ragsdale that they would demand considerably more substantial compliance with the ASTC Act before granting a new license. (Jt. App. 94-95.)[12]

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12 Defendants' claims that IDPH had always licensed Dr. Ragsdale despite his variances (Def. Br. 9) and that the level of compliance changes based on the program submitted by the provider (Def. Br. 13) are belied by the demands made of Dr. Ragsdale by IDPH enforcement personnel. (Jt. App. 94-95.) While under the 1974 version of the ASTC regulations, ASTCs were required to meet the physical plant regulations only "to the extent indicated by their described operational

(Footnote continued on the following page)

To comply with the ASTC requirements, Dr. Ragsdale would have needed to add at least 1,500 square feet of medically unnecessary space to either his original or his planned facility. (Jt. App. 145.)

The ventilation requirements in § 205.1540 of Subpart J and Table A designate air pressure relationships, exhaust requirements and a minimum number of hourly air changes nearly identical to those required of a hospital operating suite. (Jt. App. 231-32.)[13] Dr. Ragsdale's original facility had not complied with the hospital ventilating requirements but IDPH insisted on "much stricter" compliance for his new facility. (Jt. App. 94-95.)

IDPH's architectural expert, responsible for enforcing the building design requirements, admitted that he lacked knowledge about the practice of medicine (Linder, Dep. 42, 69, 81), including what is required to perform pregnancy terminations. He nonetheless demanded that new abortion facilities strictly comply with the hospital-like regulations, based on his misconception that early abortions necessarily involve incisions into the body, general anesthesia, serious hemorrhaging and blood loss, and a risk of infection from

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program," ASTC Licensing Requirements § 13.1. That provision was repealed in 1982.

13 Defendants' own witness admitted that the ASTC Act allows only one minor deviation from the air change and pressure relationship requirements of a hospital. (Jt. App. 232.) Defendants' claim that the ASTC ventilation requirements are "less stringent" than hospital requirements (Def. Br. 19) mischaracterizes this testimony.

airborne bacteria. (Dep. 40-42, 91; *see also* Jt. App. 120-21, 207.) He accordingly testified that outpatient medical facilities always needs a hospital-type operating suite with a ventilation system that reduces the spread of airborne bacteria. (Jt. App. 302-04.)

The hospital ventilation system, that can cost several hundred thousand dollars to install and operate (Jt. App. 323-24; Tr. 400), is prohibitively expensive and makes it nearly impossible to locate facilities that can be renovated to comply. (Jt. App. 122-23.) These costs are wholly unnecessary in an early abortion facility where there is no risk of infection from airborne bacteria. (Jt. App. 207.)

The diagnostic facilities required by Subpart I are identical to those required of hospitals and further inflate the cost of construction and operation. (Jt. App. 110-20.) Physicians performing abortions do not need the cost-intensive hospital laboratory suite imposed by Section 205.1380 and designed to accommodate the complex diagnostic needs of a tertiary care hospital. (Jt. App. 116-18.) Only four simple diagnostic tests are needed for a pregnancy termination (Jt. App. 117-18). A physician easily could perform these tests. (Jt. App. 118.) Under § 205.520, only a certified laboratory technician may perform them.

The storage and plant requirements in § 205.1370(k) continue to mirror the Hospital Licensing Act regulations, as do the details and finishes required by § 205.1400. Required, among other things, are: a "control station . . . to permit visual surveillance of all traffic which enters the operating suite," a janitor's closet exclusively for the surgical suite, staff locker rooms, corridors and doors large enough

to transport patients on hospital carts, and an anesthetic supply storage area. These requirements are "irrelevant" in a facility like Dr. Ragsdale's, (Jt. App. 116) and are not imposed on physicians' offices where medically analogous procedures are performed. (Jt. App. 119-20, 205-08.) These requirements do nothing but further "increase the cost of the facility, without increasing safety . . . ." (Jt. App. 117.)

D. These Statutes Burden A Woman's Effectuation Of Her Decision To Have An Abortion.

The District Court found that the impact this statutory scheme has on women seeking abortions is enormous.

> The challenged statutory and regulatory scheme, as written and as enforced, has the effect of raising the cost and limiting the availability of abortions. The scheme forces complying facilities to raise their fees, possibly beyond the economic means of some women, discourages other non-complying facilities from offering abortion services, and makes it difficult, if not impossible, for current abortion facilities to move or new abortion facilities to be constructed.

625 F. Supp. at 1225; App. 129.

The Court of Appeals affirmed these findings as not clearly erroneous. It also observed that the effect of the scheme would amount to a near prohibition on abortion

services "because of [providers'] inability to find . . . location[s] that [can] be renovated to comply with the structural and physical plant requirements of the regulations at a reasonable cost . . . ." 841 F. 2d at 1364, App. 9-10.[14]

The most costly burdens of this scheme are imposed by the physical plant and mechanical requirements. 625 F. Supp. at 1215-17, 1225-26, App. 114-17, 129-30; *see also* Jt. App. 143-47.[15] The President of Rockford Services Corporation, which owns the Medical Arts building in which Dr. Ragsdale maintained his original facility, estimated that the initial investment to place Dr. Ragsdale's office in partial compliance with the ASTC requirements would have been between $600,000 and $973,000. (Jt. App. 323-24.)

The additional expenses resulting from the defendants' demands for strict compliance with this hospital-like statutory scheme would have to be passed through to women who seek abortions. 841 F.2d at 1370, App. 22-23; 625

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[14] When Planned Parenthood of Chicago lost its lease, it was unable to find a new location that complied with the scheme, despite an extensive search of 110 potential sites. In all but two of these facilities, compliance was impossible; the corridor width requirement would have necessitated destruction of supporting walls. *See* PPFA/NAF Br. at 19-20.

[15] Ambulatory or freestanding surgical facilities often cost more to construct, on a square foot basis, than do hospitals. *See* ACOG Br. at 22-23, citing Department of Planning Services. United Hospital Fund of New York Construction Costs of Health Facilities 3 (1978); *cf.* Riffer, *Can Surgicenters Stand Alone?*, Hospitals 44, 44-48 (July 20, 1986).

F. Supp. at 1225 & n.13, App. 130 & n.13; Jt. App. 146-47, 259. Dr. Ragsdale testified that the increase in cost per procedure necessitated by defendants' demand for compliance with the ASTC regulations would be between $25 and $47, 625 F. Supp. at 1225 & n.13, App. 130 & n.13; 841 F.2d at 1370, App. 22, a 10-20% increase.[16] This estimate is based on a paying patient base of 3,300 patients per year, for a two-year period. *Id.* When the patient base is too small or too poor to support these increased charges, the health care provider is prevented, as the District Court found, from offering outpatient abortions. 625 F. Supp. at 1225-26, App. 130-131.

Health care providers who are restricted from offering abortion services to their patients either must refer these women to a hospital or to an out-of-town provider. (Jt. App. 253, 260-61, 266) Either option is burdensome to the woman.

An in-hospital early abortion may cost as much as $1,000 — three or four times the cost of that procedure done on an outpatient basis. (*Compare*, Jt. App. 253, *with*

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16 When Dr. Ragsdale first confronted the need to move his practice, he hoped to avoid any increase in the fee charged to his patients, assuming his new facilities would be allowed the same variances as had been allowed. Pl. Ex. 11, p. 5. IDPH's insistence on stricter compliance resulted in an estimated increase in the fee. (Jt. App. 94-95.) Because of the emergency nature of the proceeding, plaintiffs did not call a cost accountant to formalize Dr. Ragsdale's estimates. Defendants did not object to Dr. Ragsdale's testimony in the District Court. (Tr. 379-401.) They objected only to the admission of Dr. Ragsdale's written summaries prepared to aid in his testimony. (Jt. App. 139, 162-63.)

Jt. App. 280.) Travel also can double or triple the cost of obtaining an abortion even in an outpatient clinic. (Jt. App. 263, 265) (women suffer lost wages, lost employment, and additional child care expenses). Moreover, substantial travel following the procedure can be medically harmful and should be avoided. (Jt. App. 152-52, 263.)

The need to travel long distances makes proper follow-up care difficult. (Jt. App. 263.) Margaret Moe testified that her patients do not return to the distant facility, but rather come to her clinic if they seek follow-up care at all. (Jt. App. 263.) Some women are completely unable to find the necessary post-procedure care. (*See* Jt. App. 153.)

As a result of limited access, travel, and the escalated financial burden, many women are forced to delay the procedure (Jt. App. 263-64), increasing medical risks and cost. (Jt. App. 196-97.) Women who are forced to delay into the second trimester often must forego their decision to have an abortion altogether. (Jt. App. 264.)

The District Court also found, with full support from the record, that the abortion-specific regulations in the ASTC Act often harmed women seeking abortions. *See* 841 F.2d at 1368, 1373, App. 19, 28. Many women are hurt, in particular, by the mandatory and inflexible abortion counseling requirements in § 205.730(3). (App. 221-22.) This regulation dictates that a woman shall be counseled about alternatives to abortion, even when she needs the operation to save her own life. Jt. App. 89-90. Further, the scheme directs counseling about contraception. Under the tragic circumstances of an abortion for genetic indications, even the State's own expert agreed that the regulation was medically inappropriate. He would not want to advise the

woman about contraception but would instead want to recommend attempting pregnancy again. (St. App. 294-295.) Similarly, the ban in § 205.730(b)(2)(D) on counseling by a person with a financial stake in the abortion would deprive the pregnant woman of the opportunity to consult with her physician about abortion, if that physician might ultimately be the one to perform the abortion.

The HFPA, like the ASTC Act, causes a significant decrease in access to abortion services. It creates a government-imposed forum for opposition to abortion that each potential provider must endure before construction, renovation or relocation of any facility offering abortions. Ill. Rev. Stat. ch. 111-1/2, ¶ 1155. This greatly "impedes efforts to provide abortion services." 625 F. Supp. at 1227, App. 132. Physicians who perform outpatient surgical procedures other than abortions are not required to secure the CON permit when opening or relocating their offices. (Tr. 705; *see also* Ill. Rev. Stat. ch. 111-1/2, ¶ 157-8.3 and Ill. Rev. Stat. ch. 111-1/2, ¶ 1153.)

The District Court found that the CON requirement is inappropriate for abortion facilities, which "do not utilize public funds for construction or renovation . . . ." 625 F. Supp. at 1217 n.3, App. 140 n.3. In this context, the CON requirement does not serve the State's asserted purpose of restraining health care costs by preventing duplication of facilities. Def. Br. 6. *See* 841 F.2d at 1374, App. 31; 625 F. Supp. at 1217 & n.3. The evidence shows that a shortage of abortion facilities exists. In addition, the District Court found that "[w]ith many empty hospital beds, it may be difficult for those who desire to provide abortion services to establish a 'need' for an outpatient abortion facility." 625 F. Supp. at 1227, App. 132.

During the CON hearing, Dr. Ragsdale was sharply criticized for providing abortion services, and, at the conclusion of the hearing, he was escorted home by friends who feared for his safety. 625 F. Supp. at 1226, App. 131. The District Court thus found that the CON requirement makes it "extremely difficult, if not impossible, for those desiring to perform abortion services to construct a facility or move to a new location." 625 F. Supp. at 1226, App. 130.

E. Defendants Introduced No Evidence To Support Their Claims That The Burdens Imposed By These Statutes Further Any Legitimate Governmental Purpose.

A state employee who administers the statutes admitted that the challenged scheme does not address the single most important factor in assuring safety — the competence of the physician — and thus does not "assure quality" care. (Jt. App. 311.) As the District Court concluded, defendants made no showing that their regulatory scheme in any manner furthered their purported interest in patient safety. 625 F. Supp. at 1230, App. 137. The Court of Appeals agreed that defendants' asserted justification of protecting the health of women was unsupported, noting in particular that "the defendants failed to adduce any evidence at all of a medical justification for the physical plant requirements." 841 F.2d at 1374, App. 30. Indeed, defendants "failed to produce *any* evidence at all of . . . even [a] rational basis for the challenged statutes and regulations." 625 F. Supp. at 1230, App. 137.

Defendants' concession that they would no longer enforce the challenged scheme to prevent physicians from

occasionally performing an abortion in their offices only undercuts their argument that concerns about women's health underlie the burdensome regulation.[17] Defendants introduced no evidence of any factual or medical basis for an "exemption" allowing regulation of facilities in which experienced physicians performed a large number of procedures, and excluding from regulation smaller facilities where fewer procedures are performed. *See* 841 F.2d at 1371, App. 24.

The Court of Appeals therefore concurred with the District Court's finding of irrationality, noting that:

[17] Defendants' nonenforcement claims were contradicted by testimony before the District Court. *See* Jt. App. 259, 272-74. The District Court found that even after defendants allegedly stopped enforcing the scheme against occasional providers of abortions in 1981 (Def. Br. 6-7), IDPH continued to tell prospective providers that they would be required to comply with and be licensed under the ASTC Act before physicians could perform abortions. 625 F. Supp. at 1225 & n.14, App. 130 & n.14. Defendants' enforcement witness testified that defendants retained "absolute prosecutorial discretion" as to enforcement. (App. 273.)

Defendants never have "formally notified physicians or abortion providers of [any] decision not to enforce [any of] these provisions," 625 F. Supp. at 1228, App. 133, 841 F.2d at 1366, App. 13, notwithstanding numerous opportunities to provide such notice in connection with regular mailings. (App. 275-76.) Without repeal of the offending provisions, and with no formal commitment of nonenforcement, the District Court found that "the statutory and regulatory requirements, even if not in fact enforced, clearly 'chill' potential abortion providers." 625 F. Supp. at 1228, App. at 134. The Court of Appeals concluded that "[d]octors should not have to risk loss of their professional licenses to explore the contours of the asserted non-enforcement position." 841 F.2d at 1366, App. at 14.

> To the extent that there is any basis for distinguishing between a doctor who occasionally performs an abortion in his office and one whose practice is primarily devoted to such procedures, the regulations appear to run contrary to sound health policy. . . . The State's attempt to regulate experienced, and therefore safer, physicians, more heavily than the occasional abortion provider thus appears, as the [D]istrict [C]ourt noted, to lack even a reasonable basis.

841 F.2d at 1371, App. 24.

SUMMARY OF THE ARGUMENT

I. Section 1254(2) of Title 28, now repealed, does not extend its jurisdictional reach to encompass review of an affirmance of a preliminary injunction. *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986). Review under the discretionary provisions for certiorari contained in 28 U.S.C. § 1254(1) also would be premature and thus inappropriate. *Ashwander v. Tennessee Valley Authority*, 297 U.S. 248 (1936).

II. A woman's decision to have an abortion, like other decisions involving such intimate and individual choices as contraception, marriage, family, and travel, is a fundamental freedom vigilantly protected by the Constitution. *See, e.g., Roe*, 410 U.S. 113 (1973); *Griswold v. Connecticut*, 381 U.S. 479 (1965). Under this Court's long settled fundamental rights jurisprudence, government cannot infringe upon a protected right unless the infringement

furthers a compelling governmental interest and regulates no more broadly than is necessary to achieve that interest. During the early stages of pregnancy, state laws that infringe upon a woman's reproductive choice cannot stand unless such regulation is necessary to further and does in fact further the health of the woman or the safety of the medical procedure itself. *Roe*, 410 U.S. 113; *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983).

The challenged regulatory scheme is fundamentally incompatible with this well established doctrine. The scheme erects nearly insurmountable obstacles in the path of a woman seeking an abortion early in pregnancy, the time when the procedure is safest for her. Enforcement of the challenged scheme would make abortions unavailable in large areas of the state and would dramatically inflate the cost of this essential medical service. Further, certain of the individual regulations actually are harmful to some women.

These challenged statutes were found by both lower courts to be incongruous with the asserted governmental interests in health and safety. Rather than further these purported concerns, the statutory scheme actually undermines them. State attempts to justify regulations restricting fundamental rights with unsupported assertions that the state properly is flexing its police powers, do not survive under any standard of judicial scrutiny. *Roe*, 410 U.S. 113 (1973); *United States v. O'Brien*, 391 U.S. 367 (1968); *City of Cleburne v. Cleburne Living Center, Inc.* 473 U.S. 432 (1985).

III. The Court of Appeals appropriately affirmed the preliminary injunction of the entire challenged scheme, as it applies to early abortions, because the burdensome provisions of the scheme are integral to the scheme as a whole and thus cannot be severed. *Sloan v. Lemon*, 413 U.S. 812 (1973); *Carter v. Carter Coal Co.*, 298 U.S. 238 (1936).

ARGUMENT

I. THIS COURT LACKS MANDATORY JURISDICTION AND SHOULD NOT EXERCISE ITS DISCRETIONARY JURISDICTION TO REVIEW THE COURT OF APPEALS' AFFIRMANCE OF THE PRELIMINARY INJUNCTION.

Defendants inappropriately and prematurely seek review of an affirmance of a preliminary injunction. No mandatory jurisdiction exists under 28 U.S.C. § 1254 (now repealed) to consider a preliminary injunction. *Thornburgh*, 476 U.S. at 754-55 (1986). This Court's review at such a premature juncture would be confined, as was the Court of Appeals', "to determining whether the District Court had abused its discretion" in granting preliminary relief. *See Thornburgh*, 476 U.S. at 818 (O'Connor, J., dissenting). Plenary consideration would strip the preliminary injunction of its intended function of preserving the status quo pending final judgment on the merits, and will make litigation "more expensive, less reliable and less fair." *Id.*

The District Court ordered preliminary relief to forestall the termination of Dr. Ragsdale's medical practice but reminded the parties that the preliminary injunction could be

modified should defendants encounter difficulties enforcing the ASTC Act against non-abortion procedures. (Jt. App. 67; Tr. 858-59, App. 109-11.) At that time, defendants declined to have the preliminary injunction converted into a permanent injunction. (Jt. App. 68-71.) (DEFENSE COUNSEL: "[U]ntil the time to appeal . . . I should leave that option open for my client. If [my client] elect[s] not to appeal we can always come in and make this a permanent injunction. If they elect to appeal the preliminary, well, then, that will answer the question.")

The Court of Appeals focused its review of the preliminary injunction on whether the District Court had abused its discretion in concluding that plaintiffs had made a strong enough showing of potential unconstitutionality to satisfy the "likelihood of success" prerequisite for preliminary relief. 841 F.2d at 1366-75 & n.6, App. 14-32 & n.6. It then "ordered and adjudged" that "the preliminary injunction is affirmed." App. 102; *see also* 841 F.2d at 1376, App. 33.[18]

Concerns about premature review also strongly caution against a grant of certiorari. By declining to hear this premature appeal, the Court properly will avoid a decision on important constitutional issues in advance of the time they

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[18] Defendants misconstrue the related case of *Hedd SurgiCenter v. Turnock*, 711 F. Supp. 439 (N.D. Ill. 1989), *appeal docketed*, No. 89-1977 (7th Cir. May 10, 1989). There Judge Nordberg observed several times that the Court of Appeals in *Ragsdale* had affirmed the preliminary injunction, and, contrary to the inference left by defendants (Def. Br. 29-30), nowhere suggested that the ruling in issue is a permanent injunction.

need to be decided. *See, e.g., Webster v. Reproductive Health Services, Inc.*, ___ U.S. ___, 109 S.Ct. 3040, 3060-61 (O'Connor, J., concurring); *Ashwander*, 297 U.S. at 346-47 (Brandeis, J., concurring).

II. THE SEVENTH CIRCUIT APPROPRIATELY AFFIRMED THE PRELIMINARY INJUNCTION BECAUSE THE CHALLENGED SCHEME SIGNIFICANTLY BURDENS, WITHOUT ANY JUSTIFICATION, A WOMAN'S RIGHT TO MAKE DECISIONS ABOUT CHILDBEARING.

The challenged statutes and regulations impose an enormous burden on the right of a woman to receive a safe, early abortion in Illinois. Because of its all-encompassing regulation of early abortion procedures, this statutory scheme must fall under the weight of *Roe* and its progeny. *See, e.g., Akron*, 464 U.S. at 429 n.11 (medical evidence suggests that during the early part of pregnancy, state's interest in health of the woman "would not be served by regulations that restrict the manner in which abortions are performed by a licensed physician.").

Defendants' failure to offer any medical justification for the severe state restrictions on early abortions only emphasizes the arbitrariness of this scheme. The unjustifiable scheme is intolerable, not only under *Roe* and the cases that follow, but, more generally, under this Court's well-established fundamental rights jurisprudence, and, even under defendants' ill-conceived and unsupported rational-basis standard of review.

Roe's characterization of reproductive choice as a fundamental right protected by the Constitution was left undisturbed by last term's decision in *Webster*, 109 S.Ct. at 3067 (Blackmun, J., concurring in part, dissenting in part). Nothing in *Webster* suggests that the Court is prepared to accept a regulatory scheme, such as the one involved herein, that significantly burdens a woman's right to early abortion without any countervailing medical justification. Such a regulatory scheme is unconstitutional under any standard of review this Court might employ.

A. The Constitution Protects Against Unwarranted Governmental Interference With A Woman's Fundamental Right To Make Decisions About Contraception And Abortion.

This Court long has recognized that "the right of privacy is a fundamental personal right, emanating 'from the totality of the constitutional scheme under which we live.'" *Griswold*, 381 U.S. at 494 (Goldberg, J., concurring). The Court's decisions reflect a long history of protecting individual freedom to make private choices, even when the right to do so is not explicitly enumerated in the Constitution. *See, e.g., Skinner v. Oklahoma*, 316 U.S. 535 (1949) (right to have offspring); *Griswold*, 381 U.S. 479 and *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (contraception); *Loving v. Virginia*, 388 U.S. 1 (1967) and *Turner v. Safley*, 482 U.S. 78 (1987) (marriage); *Aptheker v. Secretary of State*, 378 U.S. 500, 505-06 (1964) (travel).

The right to private reproductive choice lies at "the very heart of [the] cluster of constitutionally protected" decisions,

Carey v. Population Services International, 431 U.S. 678, 685 (1977). If the right of privacy means anything, it is "'the right of the *individual* . . . to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.'" *Roe*, 410 U.S. at 169-70 (Stewart, J., concurring) (quoting *Eisenstadt*, 405 U.S. at 453). "That right [which encompasses the right to use contraceptives] necessarily includes the right of a woman to decide whether or not to terminate her pregnancy." *Roe*, 410 U.S. at 170 (Stewart, J., concurring). *See also Webster*, 109 S. Ct. at 3040 (O'Connor, J., concurring) ("it may be correct that use of post-fertilization contraception is protected under *Griswold*").

To allow the government to interject itself into the realm of private reproductive decision-making, taken to its logical conclusion, is to permit the government to dictate the most personal aspects of its citizens' lives — whether by prohibition or by imposition. The consequences of allowing government to make our choices are severe. *See, e.g., Buck v. Bell*, 274 U.S. 200, 207 (1927) (Fourteenth Amendment does not protect mentally retarded woman against forced sterilization because "[i]t is better for all the world [if] society can prevent those who are manifestly unfit from continuing their kind"). *See also In re A.C.*, 533 A.2d 611, (Sup. Ct., App. 1987, *vacated*, 539 A.2d 263 (D.C. Ct. App., 1988) (superior court ordered cesarean section of a non-viable fetus, over opposition of pregnant woman, family, and physician; cesarean listed as contributory factor in woman's death). "[T]he basic question is whether the 'abortion decision' should be made by the individual or by [a transient legislative] majority in the unrestrained imposition of its own, extraconstitutional value preferences."

Thornburgh, 476 U.S. at 779 (citation omitted) (Stevens, J., concurring).

B. Regulation That Restricts The Right To Have An Abortion In The Earliest Stages Of Pregnancy Has Been Upheld Only If It In Fact Furthers The Safety Of The Medical Procedure.

Regulation substantially infringing upon a fundamental right can be justified only by a compelling state interest. *Kramer v. Union Free School District*, 395 U.S. 621, 627 (1969) (right to vote); *Shapiro v. Thompson*, 394 U.S. 618, 634 (1969) (right to travel); *Sherbert v. Verner*, 374 U.S. 398, 406 (1963) (right to free exercise of religion); *Bates v. Little Rock*, 361 U.S. 516, 524 (1960) (right of free association).

Consistent with this well-settled doctrine, state regulation significantly restricting the fundamental right of reproductive choice, including abortion, is constitutional only if it is necessary to, and does in fact, further a compelling governmental interest. In *Roe*, after a lengthy examination of the religious, societal and historical concerns surrounding abortion, this Court concluded that only two compelling interests existed — the health of the woman and concern for potential life — which, under certain circumstances, would justify state regulation of abortion.[19] Each was held to

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19 Unlike the state in *Webster*, defendants in this litigation have not asserted an interest in "potential" life as justification for this regulatory scheme. Any interest in protecting the potentiality for human life becomes compelling when the fetus "has the capability of meaningful

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"grow[ ] in substantiality as the woman approaches term and, at a point during pregnancy each becomes 'compelling.'" *Id.* at 163-64.

Subsequent decisions leave no doubt that the compelling points were left "flexible for anticipated advancements in medical skill." *Colautti v. Franklin*, 439 U.S. 379, 387-89 (1979). *See also Akron*, 462 U.S. at 429 n.11. *Roe* thus did not impose a "rigid trimester framework," but instead adopted a procedure by which to analyze the competing interests involved — leaving room for appropriate regulations if "those restrictions are tailored to the recognized state interests." *Roe*, 410 U.S. at 165.

Because the abortion procedure in all its aspects is inherently and primarily medical, "basic responsibility for it must rest with the physician." *Roe*, 410 U.S. at 167. Medical knowledge leaves no doubt that abortion is safer than childbirth.[20] During the early stages of pregnancy, states permissibly can regulate abortion only if: 1) the regulation does not burden the abortion decision or its effectuation, *see, e.g., Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976) (informed consent and reporting provisions integral to procedure and, at most, have *de minimus* impact on abortion right); or,

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life outside the . . . womb," *Roe*, 410 U.S. at 164, a period of pregnancy not implicated by the challenged scheme.

20 See discussion at pp. 8 - 11 and authorities underscoring the safety of legal abortion.

2) the regulation is essential to furthering, and does in fact further, the safety of the medical procedure, *see, e.g.*, *Connecticut v. Menillo*, 423 U.S. 9 (1975) (state can require that abortions be performed only by state-licensed physicians); *Planned Parenthood Association v. Ashcroft*, 462 U.S. 476 (1983) (pathology examination requirement upheld because it had only minimal impact and was "absolutely necessary" from a medical standpoint).[21]

The challenged scheme satisfies neither criteria. In the face of such significant infringements on a fundamental right, this Court's jurisprudence demands the actual furtherance of a compelling governmental interest. Both courts below found that the challenged statutes do not further health or safety, but rather, are either irrelevant to these asserted state interests or actually undermine them.

C. The District Court Finding That This Scheme Significantly Restricts Early Abortions Is Not Clearly Erroneous.

This scheme, enacted soon after *Roe*, expressly restricts all first trimester abortions to hospital-like settings.[22] For

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21 The Court also has provided that "[i]f an individual practitioner abuses the privilege of exercising proper medical judgment, the usual remedies, judicial and intra-professional, are available." *Roe*, 410 U.S. at 166.

22 The scheme is abortion-specific, from its definition of an ASTC and the MPA prohibition against performing any abortion in a facility other than a hospital or a licensed ASTC, to the ASTC regulations' subpart G and other individual provisions that add stringent requirements applicable only to abortions. *See* Ill. Rev. Stat. ch. 111, ¶ 4400-22, App. 193; Ill. Rev. Stat. ch. 111-1/2, ¶¶ 157-8.3(A),

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many years, defendants enforced the licensure requirement against all providers. Defendants claim they now exempt from ASTC licensure those who would perform only an occasional abortion. This exemption neither has been enacted through amendment nor announced to the health care providers governed by the regulatory reach of the laws. The resulting confusion predictably chills those who would otherwise offer abortion services. 625 F. Supp. at 1225, App. 130.[23]

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8.61; 77 Ill. Admin. Code, Ch. 1, §§ 205.120(b)(9)(F), .520(b)(3), .610(e), and .710 - .760. (App. 203-50.) Even defendants' description of the purpose of the ASTC Act in their brief singles out abortion for special comment. (Def. Br. 5.) As the Seventh Circuit noted, the legislative history indicates that "the ASTC Act was enacted primarily with abortion clinics in mind and only applied to outpatient surgical clinics generally in an effort to save the statute from unconstitutionality." (App. 21.)

Defendants misrepresent this legislative history with their claim that the sole purpose of the ASTC Act was "to regulate same-day surgical facilities which perform minor surgery." (Def. Br. 36.) Defendants then selectively included in their brief's appendix only one page of this legislative history, omitting the remainder which reveals that the General Assembly also specifically intended to regulate abortion and to confine abortions to hospital-like facilities. Pl. App. A.

23 As the Court of Appeals observed, defendants' evidence of nonenforcement was at best "equivocal." 841 F.2d at 1363, App. 8. Notwithstanding multiple revisions of the statutes and regulations, defendants have made no effort to amend the laws to reflect their asserted policy. Even the most recent amendments to the regulations which were approved by the ASTC Act Board on May 31, 1989, and which become effective November 1, 1989, do not rescind the regulations defendants claim not to enforce. Illinois Register, October 13, 1989.

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Even without certain of the abortion-specific provisions (Def. Br. 31), this scheme impermissibly interferes with the ability of providers such as Dr. Ragsdale to offer essential health services.

Based on the evidence presented at trial, the Seventh Circuit affirmed the district court's factual findings: (1) that the scheme imposed "a very real and a very heavy burden on the right of a woman to decide to terminate her pregnancy," 625 F. Supp. at 1227, App. 132; (2) that some of the challenged regulations actually were harmful from a medical standpoint, 841 F.2d at 1368, 1373-74, Jt. App. 18-19, 29; and (3) that this significant burden was imposed "'[with no] medical justification whatsoever.'" *Id.* at 1373, App. 29. Defendants have provided no record support to challenge these findings.

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Defendants, or their successors, are free at any time to choose to enforce the challenged provisions as written. *See City of Mesquite v. Aladdin's Castle, Inc.*, 455 U.S. 283, 289 (1982) (challenge not moot because amendment of ordinance would not preclude reenactment of challenged provision). In this light, a live federal controversy undoubtedly remains. *Contrast, e.g., C.I.O. v. McAdory*, 325 U.S. 472 (1945) (Def. Br. 33) (no threat of unconstitutional construction); *Webster*, 109 S.Ct. 3040 (Def. Br. 33) (plaintiffs did not contest defendants' construction of challenged statute); *Green v. Mansour*, 474 U.S. 64 (1985) (Def. Br. 34) (no ongoing violation of federal law). Only with regard to the second trimester hospitalization requirement is unenforceability clear. 77 Ill. Admin. Code, Ch.1, subpart b, § 205.750 (same requirement declared unconstitutional by this Court in *Akron*.)

The challenged scheme "without question, cause[s] abortion providers to incur great construction and renovation costs." 625 F. Supp at 1217, App. 117. These up-front costs inhibit would-be providers, and, coupled with the burdensome CON requirement,[24] "make difficult, if not impossible, the relocation of an existing abortion practice or the commencement of a new one." 841 F.2d at 1370 n.9, App. 22 n.9. The challenged scheme thus effected a significant decrease in the availability of, and access to, safe, legal abortions. 625 F. Supp. at 1227, App. 132-33. As a result of limited access, women are forced to travel to obtain medical care which results in delay that increases costs and health risks and in some cases prevents altogether the effectuation of the abortion decision. *Id.*

As this Court explained in *Carey*, a state scheme that "burden[s] an individual's right to decide to . . . terminate pregnancy by substantially limiting access to the means of effectuating that decision . . ." is as offensive to constitutionally sanctioned notions of personal privacy as regulation that "prohibits the decision entirely." *Carey*, 431 U.S. at 688; *compare Akron*, 462 U.S. at 461-62 (O'Connor, J., dissenting). The scheme challenged here unquestionably "places a significant obstacle in the path of women seeking an abortion," *Akron*, 462 U.S. at 434, both

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24 Given the current climate of the abortion debate, the District Court found that the CON requirement "subjects both the owner of the building and the proposed provider to the possibility of harassment and even threats of violence to themselves, their families and their friends." 625 F. Supp. at 1226, App. 131. *Compare Bates v. Little Rock*, 361 U.S. at 324. ("[t]his repressive effect, while in part the result of private attitudes and pressures, was brought to bear only [as a result of] the exercise of governmental power . . .").

by significantly decreasing the availability of early abortion services and by increasing the cost of the procedure when it is available.[25] The practical impact of Illinois' regulation effectively is to prohibit abortion in many parts of the state. *Compare Danforth*, 428 U.S. at 79 (1976), as cited in *Akron*, 462 U.S. at 464 (O'Connor, J., dissenting) (because prostaglandin abortions unavailable in Missouri, ban on saline abortions unconstitutional because it had "the effect of inhibiting the vast majority of abortions after the first 12 weeks").[26] This scheme, which covers all early

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25 Defendants' use of lower court abortion cases only underscores the import of plaintiffs' showing of burden here. *See, e.g., Friendship Medical Center, Ltd. v. Chicago Bd. of Health*, 505 F.2d 1141 (7th Cir. 1974), *cert. denied*, 420 U.S. 955 (1975) (Chicago ordinance imposing structural, equipment and staffing regulations like those at issue here invalidated because impermissible interference with right to effectuate abortion choice); *Mahoning Women's Center v. Hunter*, 610 F.2d 456 (6th Cir. 1979), *vacated on other grounds*, 447 U.S. 918 (1979)(same); *Birth Control Centers Inc. v. Reizen*, 743 F.2d 352, 364-65 (6th Cir. 1984) (Def. Br. 37-38.) (struck staffing, structural and equipment requirements because they imposed a significant burden on the effectuation of the abortion right during the first trimester). *Hodgson v. Lawson*, No. 4-74-155 (D. Minn., March 7, 1977) (regulations upheld in *Hodgson v. Lawson*, 542 F.2d 1350 (8th Cir. 1976) (*per curiam*) (Def. Br. at 38 n. 7) (struck on remand after evidentiary hearing which revealed that the regulations imposed significant and unjustified burdens); *see also Baird v. Department of Public Health*, 599 F.2d 1098 (1st Cir. 1979) (regulatory scheme upheld based on stipulated record with no evidence of impact on the fundamental abortion right).

26 Defendants respond to the demonstrated reduction in abortion services with the claim that abortions remain available in "doctors' offices" and "hospitals." (Def. Br. 44.) A committee of the General Assembly recognized a scarcity of abortion services as long ago as 1978. *See* Report to House Human Resources Committee, Def. App. A-52 to 53 ("many physicians and hospitals throughout the State have

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abortions, severely impedes access to abortion services — imposing an even greater burden than did the second trimester hospitalization requirement struck down in *Akron*.[27]

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elected not to provide [abortion] services" noting, for example, "there are no clinics or hospitals in the City of Springfield that will provide abortions in the first trimester"). Large areas in Illinois remain without any abortion provider. 625 F. Supp. at 1226, App. 132., Tatalovich & Daynes, *The Geographic Distribution of U.S. Hospitals with Abortion Facilities*, 21 Fam. Plan. Persp. 81-84 (1989).

The combined impact of a bill pending in the Illinois General Assembly, proposing a *Webster*-like ban on abortions in public hospitals, coupled with the almost complete restriction of private outpatient clinics contemplated by this scheme, would effectively prohibit abortion services in Illinois.

27 At least two hospitals within the City of Akron itself performed second-trimester abortions. No other facility in Rockford performed any abortions. Moreover, in *Akron* there was no evidence to suggest that "other hospitals in nearby areas did not provide second-trimester abortions." 462 U.S. at 464 (O'Connor, J., dissenting). Here, however, there is extensive evidence of the drastic limitation on access caused by the challenged scheme. *See also* PPFA/NAF Br. 21-24.

D. Defendants Fail To Justify This Burdensome Statutory Scheme With Any Evidence To Show The Furtherance Of A Legitimate, Let Alone Compelling, Governmental Interest.

In the face of these demonstrated restrictions on a fundamental right, it was incumbent upon defendants to prove, at a minimum, that this scheme, as applied, furthered the State's asserted interest in the safe performance of the abortion procedure. *Thornburgh*, 476 U.S. at 759; *see also Gibson v. Florida Legislative Investigation Committee*, 372 U.S. 539, 546 (1963) (where state regulation "infringe[s] substantially" on a fundamental right, the State must "convincingly show a substantial relation between the [regulation] and a subject of overriding and compelling state interest."); *Aptheker*, 378 U.S. at 507-08, 514 (where effect of regulation is to significantly infringe a protected right, government must establish a careful fit between the imposing regulation and the government's asserted purpose).

This Court will not excuse burdensome regulation simply because the State waves the talisman of its "police power." Instead, in the face of significant obstacles to a fundamental right, such as those shown here, the Court examines, as it did in *Roe*, the "respective interests involved" and the nature of the relationship between the regulations and the state's asserted interests to determine whether the imposition on the protected right can be justified. *See Roe*, 410 U.S. at 165. *See also Doe*, 410 U.S. at 195 (even purported health regulations must be narrowly drawn and actually further substantial government interest); *Carey*, 431 U.S. at 696 ("[w]hen a State, as here, burdens the exerciser of a fundamental right, its attempt to

justify that burden . . . requires more than a bare assertion . . . that the burden is connected to . . . a [state] policy."); *Thornburgh*, 476 U.S. at 759 (states cannot, under the guise of protecting women's health, impose restriction on abortions which fail to advance that interest).

Most recently, in *Webster*, the Court upheld the 20-week testing requirement. There, the State asserted its interest, which the Court recognized in *Roe* as compelling, in protecting the viable fetus. *Webster*, 109 S.Ct. at 3060, 3062 (O'Connor, J., concurring). The provision, as construed by the Court, acceded to the discretion of the physician to determine what tests are necessary, "would not be medically imprudent," would "only marginally, if at all, increase the cost of an abortion," and thus would not "unduly burden" the fundamental right. *Id.* at 3063. *Compare Ashcroft*, 462 U.S. at 489-90. (pathology requirement upheld because impact on fundamental right was justified by State's evidence showing requirement was medically necessary).

Here, by contrast, the factual record exposes the emptiness of defendants' asserted justifications. 841 F.2d at 1370-74. In response to the significant restrictions plaintiffs proved, *see supra* at 16, defendants presented no evidence to show that compliance with the scheme furthered the only interest they asserted: assurance of safe early abortions.[28]

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28 Defendants attempt to excuse their inability to justify these burdens, citing *Harris v. McRae*, 448 U.S. 297 (1980). (Def. Br. 35.) *Harris* is inapposite. The *Harris* Court differentiated between situations, such as the one presented here, in which the government is the perpetrator of the burden and those in which the government simply withholds funding for the exercise of an otherwise constitutionally

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Before this Court, defendants continue to focus on a few innocuous provisions — as if to induce the Court to overlook the burdensome provisions that cumulatively impede access to safe, legal abortions in Illinois.

Indeed, defendants' purported interest in a pregnant woman's health has been seriously compromised by this regulatory scheme. The regulations necessitating the cost increases were shown to be medically unnecessary to the performance of a safe early abortion. *Compare Ashcroft*, 462 U.S. at 487, *cited in Ragsdale*, 841 F.2d at 1370, App. 22-23.[29] Indeed, uncontroverted evidence showed some of the requirements to be medically harmful (*see, e.g.*, restrictions limiting physician counseling, compelling

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protected freedom. 448 U.S. at 316. *See also Webster*, 109 S.Ct. at 3059 (O'Connor, J., concurring) (citing *Harris*; *Maher v. Roe*, 432 U.S. 464 (1977); *Poelker v. Doe*, 432 U.S. 519 (1977)). And, where, as here, the government significantly "impinge[s] on a . . . fundamental right[ ]" the highly deferential standard urged by defendants never has been applied. *See Harris*, 448 U.S. at 322.

29 Defendants claim that evidence showing the regulatory scheme to be medically unnecessary cannot factor into the Court's review of the regulation. (Def. Br. 40.) To the contrary, "when the experts below testified that a requirement was not 'medically necessary,' they meant by that term that it had no real relationship to safety or health." 841 F.2d at 1368, App. 18. "[M]edical necessity," as used during trial, "is entirely consonant with the standards to be applied to regulations regarding first trimester abortions." *Id.* (citing *Akron*, 462 U.S. at 430; and *Ashcroft*, 462 U.S. at 487.).

inappropriate counseling, and compelling construction of inappropriate facility).[30]

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30 Defendants and their amici claim that this scheme protects women's health. The emptiness of this claim is exposed by the scheme's own ineffectiveness. Five years after enactment, a *Chicago Sun-Times* investigation revealed serious patient-care abuses by IDPH licensed abortion providers. *See, generally*, "The Abortion Profiteers," *Chicago Sun-Times* (1978).

Seven years later, at the preliminary injunction hearing below, defendants' were unable to produce any evidence to demonstrate that the scheme, even as amended, guards health or safety. In fact, one of defendants' own enforcement witnesses conceded that, at the time of trial, at least two of the facilities investigated by the *Sun-Times* remainéd licensed providers (Ramsey, Tr. 59-60.), despite continuing criticism. They remain licensed today.

The single most important factor in the safety of any procedure — the skill and experience of the physician — is the factor the challenged scheme pointedly ignores. If the legislature or defendants were seriously concerned with protecting the health of Illinois women, they would long ago have taken their own advice:

> The present program of the IL Dept. of Public Health devotes too much attention to inspections of the physical plants and patient records, rather than an ongoing evaluation of clinic operations and patient care.

Report to the House Human Resources Committee ("Comm. Rep."), Def. App. 26. The Committee also recognized that:

> Public agencies and facilities . . . have an obligation to respond to the interests and needs of women seeking abortions. . . . Services should be available in all areas of the state.

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Defendants mischaracterize the breadth of discretion afforded the state to regulate in the name of health and safety. Respect for the state's police power:

> does not mean that in determining whether a regulation imposes an "undue burden" on the *Roe* right [the Court] defer[s] to the judgments made by state legislatures.

Akron, 462 U.S at 465 (O'Connor, J., dissenting).

This Court consistently has required more than mere assertions of unsupported public health and safety concerns to justify government's use of its police powers. For example, in the area of state highway safety regulation, accorded a strong presumption of validity, *Bibb v. Navajo Freight Lines Inc.*, 359 U.S. 520, 524 (1959); *Raymond Motor Transportation, Inc. v. Rice*, 434 U.S. 429, 443-44 (1978), this Court does not automatically uphold regulation which infringes on other constitutional interests. *See Bibb*; *Raymond*; *Kassel v. Consolidated Freightways Corp.*, 450 U.S 662, 670-671 (1981) (where the "State's safety interest has been found to be illusory, and its regulations impair significantly the federal interests in efficient and safe interstate transportation, the state law cannot be harmonized

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Comm. Rep., Ref. App. 52-53.

Eleven years after this report, women in many areas of the state lack access to abortion services; access denied them by defendants' restrictive and cost-prohibitive statutory scheme.

with the Commerce Clause"); *see also Dean Milk Co. v. Madison*, 340 U.S. 349, 354 (1951) (ordinance restricting interstate delivery of milk not valid simply because it professes to be a health measure . . ."); *Pike v. Bruce Church, Inc.*, 397 U.S. 137, 142 (1970) ("[I]f a legitimate local purpose is found, then the question becomes one of degree and the extent of the burden that will be tolerated will of course depend on the nature of the local interest involved, and on whether it could be promoted as well with a lesser impact on [protected] activities").

Here, the irrationality of the express statutory exemptions, coupled with exemptions resulting from defendants' alleged nonenforcement policy, negates defendants' assertions that they are regulating to assure safety. The statute expressly exempts from coverage oral surgery, often performed under general anesthesia and thus far more dangerous than an early abortion performed under local anesthesia.[31] Defendants' claimed policy of exempting physicians who provide only a few abortions produces, as the Court of Appeals concluded, the anomalous and irrational result of regulat[ing] experienced, and therefore safer, physicians more heavily than the occasional abortion provider." 841 F.2d at 1371, App. 24. *Compare Kassel*, 450 U.S. at 669 (exemptions weakened presumption of

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[31] Although in certain exceptional situations, general anesthesia is appropriate for early abortions, this does not justify medically inappropriate regulation of all early abortions, the majority of which are performed under local anesthesia. Government may not regulate more broadly than is necessary to further the compelling governmental interest, *see Bolger v. Young Drug*, 463 U.S. 60, 73 (1983), especially when the impact of such a regulatory scheme is to substantially reduce access to an important right.

validity normally accorded highway safety regulation); *Raymond*, 434 U.S. at 447 (same).[32]

Where as here, the State has failed to show the furtherance of a legitimate basis, let alone a compelling state interest, for regulations that significantly burden the right to choose abortion, those regulations must, as a matter of law, remain enjoined.

E. Defendants' Claim That A Rational Basis Standard Applies Because The Scheme Is Abortion-Neutral Is Baseless In Law And Fact.

Defendants' argument that the challenged laws are "abortion-neutral" and thus should be upheld under a deferential rational basis standard (Def. Br. 34-35) ignores the factual reality of the abortion-specific scheme challenged here, *supra* at 32, and well-established constitutional principles. Notwithstanding defendants' protestations to the contrary (Def. Br. 35-40), a rational basis standard of review is "wholly incompatible with the existence of the fundamental right recognized in *Roe v. Wade*." *Akron*, 462 U.S. 420-21 n.1.

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32 Defendants cannot now avoid this anomaly by suggesting that the direct control a physician exercises over staff and functions in his or her office differs appreciably from the control a physician wields over an outpatient facility, (Def. Br. 37) for they offered no evidence below to support such a claim. *See* 841 F.2d at 1371, App. at 24. Indeed, the evidence introduced by plaintiffs demonstrated unequivocally that Dr. Ragsdale exercised complete and direct control over all staff and medical decisions at his clinic. *See* 841 F.2d at 1371.

This Court never has adopted a highly deferential level of scrutiny to review even unquestionably neutral legislation, if such legislation inhibits a fundamental right. *United States v. O'Brien*, 391 U.S. 367 (1968). It is a basic premise of constitutional law that "[a] regulation neutral on its face may, in its application, nonetheless offend the constitutional requirement for governmental neutrality if it unduly burdens" a fundamental right. *Wisconsin v. Yoder*, 406 U.S. 205, 220 (1972) (neutral compulsory education law could not be applied to Amish people whose First Amendment right to freely exercise their religion was burdened).[33]

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33 Defendants' citation of cases addressing time, place and manner restrictions, and their suggestion that such cases support a bare bones rational basis analysis fails. These cases represent a discrete body of law governing only narrowly-tailored, content-neutral regulation of speech; this case law demands that regulations which burden speech restrict this right no more than necessary to actually achieve the approved governmental interest.

For example, in *Ward v. Rock Against Racism*, _____ U.S. _____, 109 S.Ct. 2758 (1989), (Def. Br. 38), the City introduced substantial evidence of problems stemming from park concerts, including both insufficient and excessive amplification, and further demonstrated that the challenged ordinance resolved those problems. Upholding this regulation, the Court cautioned that even content-neutral regulation of speech "must be narrowly tailored to serve the government's legitimate content-neutral interests" and that "this standard does not mean that time, place, or manner regulation may burden substantially more speech than is necessary to further the government's legitimate interests." 109 S.Ct. at 2757 (citing *Martin v. Struthers*, 319 U.S. 141 (1943)). Here, both courts below observed that there is no evidence of *any* legitimate justification for the regulation, let alone that the regulations are narrowly tailored to further legitimate State interests.

(Footnote continued on the following page)

Moreover, even when neither a fundamental right nor a quasi-suspect classification is implicated, the government still must make an evidentiary showing to demonstrate the "rational basis" for believing that a challenged restriction or classification will advance a legitimate governmental interest. This Court will not uphold a law whose relationship to achieving the asserted goal "is so attenuated as to render [it] arbitrary or irrational." *City of Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 446 (1985) (irrational classification violates equal protection). *See also Schware v. Board of Bar Examiners*, 353 U.S. 232 (1957).

Here, the evidence demonstrates that the regulatory scheme significantly burdens the right to have an abortion in the early stages of pregnancy. Both lower courts concluded that defendants failed to produce any evidence of "a compelling or even a rational basis" for the challenged scheme, the imposition of which fails to further in any way the asserted interest in protecting the safety of women seeking abortions. 625 F. Supp. at 1230, App. 138; 841 F.2d at 1373, App. 29. Without this essential connection, the arbitrary scheme cannot pass even a rational basis test. *See Zobel v. Williams*, 457 U.S. 55, 61-63 (1982) (striking Alaska statute because the scheme bore no relation to two of the state's three objectives, and third objective was improper.).

(Continued)

For similar reasons, defendants' citation of *City of Renton v. Playtime Theatres, Inc.*, 475 U.S. 41 (1986), and *Arcara v. Cloud Books, Inc.*, 478 U.S. 697 (1986) (Def. Br. 39), is unpersuasive.

III. THE SEVENTH CIRCUIT APPROPRIATELY AFFIRMED THE DISTRICT COURT'S PRELIMINARY INJUNCTION OF THE CHALLENGED SCHEME IN ITS APPLICATION AS AN INTEGRATED WHOLE TO EARLY ABORTION PROCEDURES.

The preliminary injunction prohibits enforcement of this scheme only as it applies to early abortion procedures. By preserving defendants' authority to enforce the scheme against outpatient facilities in which non-abortion surgical procedures are performed, including those facilities in which both abortion and non-abortion procedures are offered, the District Court properly removed only the narrowest possible range of procedures from the enforcement power of the state. *Compare McElroy v. United States*, 361 U.S. 281 (1960) (ruling that Uniform Code of Military Justice cannot be applied constitutionally to civilians does not invalidate Act's jurisdiction over military personnel).

Defendants' argument that, with this injunction, the lower courts "emasculate[d]" the State's ability to regulate health and welfare (Juris. St. 21) is nothing more than an attempt to obscure the narrow terms of the injunction. *See supra* at 6-7. In affirming the preliminary injunction, the Court of Appeals examined the interrelated nature of the burdensome substantive provisions resulting from the central licensing requirement and concluded that "*in this case* . . . the State may not require separate licensure . . .." 841 F.2d at 1371, App. 24 (emphasis added). Thus, the Seventh Circuit did not, as defendants argue, hold that "under *Roe*, the State may not require licensure of abortion facilities." (Def. Br. 25.) Moreover, after discrediting the

licensing process, the Court alternatively "analyze[d] those specific substantive aspects of the regulations focused on at trial which render the scheme unconstitutional as a whole." 841 F.2d at 1371-72, App. 25. Included in this analysis were the physical plant requirements, the CON requirement, and certain of the abortion-specific regulations most intrusive of the physician-patient relationship. (*Id.* at 1372, 73, App. 26-29.)[34]

The Court of Appeals properly refused defendants' invitation to rewrite the challenged legislation. Severance is inappropriate when the questioned provisions are "an integral part of the statutory enactment viewed in its entirety." *Id.* at 1375, App. 32 (quotations omitted). To have stripped away the licensing and physical plant requirements would have left the scheme "with very little resemblance" to the scheme enacted by the General Assembly. *Id.* at 1375, App. at 33. *See, e.g., Sloan v. Lemon*, 413 U.S. 825, 834 (1973) (severance inappropriate when result is "to create a program quite different from the one the legislature actually adopted"); *Carter v. Carter Coal Co.*, 298 U.S. 238, 313 (1936) (severance inappropriate when objectionable provisions so interwoven with other

34 Ironically, defendants criticize the Court of Appeals' construction of the regulation barring the physician from providing counseling, claiming that "the construction was arrived at without the benefit of any evidence whatsoever as to the administrative interpretation . . . of this regulation or input from the enforcement agency." (Def. Br. 47.) Defendants themselves chose not to offer such evidence if it in fact existed. And if it does, defendants' argument illustrates once again the incompleteness of this preliminary injunction record.

regulations that separation impossible); *Hill v. Wallace*, 259 U.S. 44, 70-71 (1922) (same).[35]

In sum, the Court of Appeals' review of this scheme as a whole was not erroneous and presents no federal issue deserving of Supreme Court review of this affirmance of a preliminary injunction.

35 Defendants' contention here that somehow the Seventh Circuit erred because the abortion-specific provisions "were not specifically challenged below" (Def. Br. at 25 and 45) reflects defendants' repeated refusal to comprehend plaintiffs' challenge. That challenge focused on the cumulative impact of the regulatory scheme as a whole, with a special emphasis on the scheme's most burdensome provisions. Moreover, as the Seventh Circuit pointed out, defendants "urge[d] that [the court] specifically analyze each provision" independently of the integrated scheme. 841 F.2d at 1358, App. 32.

CONCLUSION

For the reasons set forth herein, defendants have failed to establish that this Court should exercise its limited jurisdiction to review this affirmance of a preliminary injunction. Accordingly, the appeal should be dismissed. In the alternative, given the unjustified burdens this scheme imposes on the exercise of a fundamental right, the Court of Appeals' decision should be affirmed.

Respectfully submitted,

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Dated: October 14, 1989

APPENDIX

[redacted]

[redacted]

[redacted]

APPENDIX A

LEGISLATIVE HISTORY

SENATE DATE: May 9, 1973

PRESIDING OFFICER (SENATOR MOHR):

Any amendments from the Floor? 3rd reading. SB 947, Senator Netsch. SB 992, Senator Rock. SB 1027, Senator Daley. SB 1051, Senator Rock. Senator Rock.

SENATOR ROCK:

Again, with the companion bills 1049 and 1050 Senator Wooten is now the chief sponsor, I'm told, he does have an amendment. Senator Wooten, I would ask the Secretary to change the Calendar [to] reflect the fact that Senator Wooten is the chief sponsor of SB 1051.

PRESIDING OFFICER (SENATOR MOHR):

Senator Wooten will be shown as the chief sponsor of SB 1051. Senator Wooten, you wish the bill advanced?

SENATOR WOOTEN:

Yes.

SECRETARY:

SB 1051.

(Secretary reads title of bill). 2nd reading of the bill. The Committee on Public Health, Welfare and Corrections offers one amendment.

PRESIDING OFFICER (SENATOR MOHR):

Senator Wooten moves the adoption of Amendment #1, all those in favor signify by saying aye. Opposed? Amendment #1 is adopted. SB 109 ...

SECRETARY:

Amendment #2 by Senator Wooten.

PRESIDING OFFICER (SENATOR MOHR):

Senator Wooten moves the adoption of Amendment #2, all those in favor signify by saying aye. Opposed? Amendment #2 is adopted. Any further amendments? Amendments from the Floor? 3rd reading. SB 1094, Senator Bartulis.

SECRETARY:

SB 1094.

(Secretary reads title of bill). 2nd reading of the bill. No Committee amendments. Amendment #1 by Senator Bartulis.

PRESIDING OFFICER (SENATOR MOHR):

Senator Bartulis would you explain your amendment.

SENATOR BARTULIS:

... Thank you, Mr. President, members of the Senate, Amendment #1 just changes a few words to dress up the bill.

PRESIDING OFFICER (SENATOR MOHR):

Senator Bartulis moves the adoption of Amendment #1 all those ... Senator Rock.

SENATOR ROCK:

I just wonder, I do not have a copy. ... I difficult as you know to dress up a bad bill, I just wondered how it's dressed up.

PRESIDING OFFICER (SENATOR MOHR):

... Page boy. Senator Bartulis moves the adoption of Amendment #1, all those in favor signify by saying aye. Opposed? Amendment #1 is adopted. Any amendments from the Floor? 3rd reading. SB 1145, Senator Romano, hold it. Does anybody request moving Senate Bills from 2nd to 3rd? That ... didn't happen to be on the Floor when we advanced these bills? Senator Mitchler?

SENATOR MITCHLER:

What number?

SENATE DATE: May 29, 1973

SENATOR WOOTEN:

Mr. President, since these three bills, 1049, 1050, 1051 are nonpartisan but extremely important I would like to call them when we have a full attendance, a reasonably close to full attendance. Not sure where we stand now.

PRESIDING OFFICER (SENATOR GRAHAM):

SB 1049.

SECRETARY:

SB 1049 (Secretary reads title of bill). 3rd reading of the bill.

PRESIDING OFFICER (SENATOR GRAHAM):

Senator Wooten.

SENATOR WOOTEN:

Well, Mr. President, I distributed to all members of the Senate last Thursday an outline of these three bills, which begin with 1049. Some statements relative to the Supreme Court decisions relating to abortion, some editorial comments, some analysis and I hope that everyone has had an opportunity to look this material over. Unfortunately, this comes up so quickly I'm having to scramble for material now.

PRESIDING OFFICER (SENATOR GRAHAM):

That's all right, you have time Senator.

SENATOR WOOTEN:

But, the ... the first bill, I believe all of the ... Sections are explained. I would like to explain that I accepted these bills with great reluctance initially. They were drafted by the Illinois State Medical Society, the Illinois Medical Association, the

Department of Public Health. Like many others, I was loathe to have my name associated with any bill that had the word abortion in it unless it *** . However, after *** Senate were probably not going to pass. I further realized that we would have ... we perhaps would be in a situation where we would have no regulations relating to abortion. Now, while I am ethically opposed to abortion and I realize that we may differ on this particular aspect, I would like to point out that what this law intends to do is to regulate abortion to bring it under some kind of restriction but only within the bounds clearly marked out by the Supreme Court. I feel it is futile for us to pass legislation which will be declared unconstitutional. I am reluctant to do anything to encourage the spread of abortion. I think this is legislation on which we can stand in some kind of acceptable middle ground. I would like to point out that there is what I consider a very serious defect in the definition, but this goes back to the Supreme Court and we are powerless to do anything about it, and that is the three trimesters. I think every physician or everyone, who like myself has had some background in embryology and physiology knows that the selection of the second trimester terminal date as six months is unrealistic. Twenty weeks is more nearly the accurate figure. I know because I have a son who was born at about that period of time, and he is a healthy youngster today, so

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"***" Represents portions of history where microfiche is illegible.

I know ... I know myself from my own experience and my background that that definition is wrong. But I would point out, that in that case as in so many others, we are absolutely caught on the Supreme Court decision. I think we can talk at great length about how much we deplore or for some how much we applaud this decision. But what I *** to do in this legislation is merely to regulate abortions in the State of Illinois in a way that is acceptable to the great mass of people. And you've had an opportunity to read that material and look it over. I'll be very happy to answer questions. I might note that I put a couple of amendments on this bill, and the first one would occur on page 2, down around line 17, Section B, second trimester. It has to do with measures for life support available. I added to that available and utilized if there is any sign of viability in the fetus. Now, this goes a little bit beyond the Supreme Court[']s original decision, but still it seems to me that personally I have a compelling interest in keeping that language in there. Second, some legal authorities have began to speak about the State's compelling interest, developing as the fetus develops, and third, there is the severability clause in here, if for some reason there is objection to that language, it can be stricken. I've also added a new Section 8, which is a ban on experimentation of the fetus. There's been some very unhappy results of

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"***" Represents portions of history where microfiche is illegible.

this sort of thing in England that we would certainly like to circumvent in this country. And I'll be happy to answer any question.

PRESIDING OFFICER (SENATOR GRAHAM):

Senator Sours.

SENATOR SOURS:

Senator Wooten, will probably need a little help on this, so maybe I can intervene. This is a good bill. It had an extensive hearing in Judiciary and what ... there are no theological embellishments for those who want to follow the Supreme Court case literally, as I want to. As the matter now stands without this bill, without this becoming the law, abortion is not a medical act. It ... and because it is not by definition a medical act, it cannot be controlled. And that would suggest that there are any number of non-medical people today in the absence of this law performing abortions. And when I say non-medical, I mean people who have no knowledge, who have no formal education, and are simply making a racket out of it. This is a good bill. I know of nothing wrong with it, and it does merit the support of both sides.

PRESIDING OFFICER (SENATOR GRAHAM):

Is there further discussion? If not, the question is shall SB 1049 pass. The Secretary will call the roll.

ACTING SECRETARY (MR. WRIGHT):

Bartulis, Bell, Berning, Bruce, Buzbee, Carroll, Chew, Clarke, Conolly, Course, Daley, Davidson, Donnewald, Dougherty, Fawell, Glass, Graham, Harber Hall, Kenneth Hall, Hynes, Johns, Keegan, Knuepfer, Knuppel, Kosinski, Latherow, McBroom, McCarthy, Merritt, Mitchler, Howard Mohr, Don Moore, Netsch, Newhouse, Nimrod, Nudelman, Ozinga, Palmer, Partee, Regner, Rock,

Roe, Romano, Saperstein, Savickas, Schaffer, Scholl, Shapiro, Smith, Sommer, Soper, Sours, Swinarski, Vadalabene, Walker, Weaver, Welsh, Wooten, Mr. President.

PRESIDING OFFICER (SENATOR GRAHAM):

Carroll, aye. Buzbee, aye. Palmer, aye. Johns, aye. On this question the yeas are thirty, the nays are none, voting present is four. The bill having received a constitutional majority is therefore declared passed. Senator Johns moves that having voted on the prevailing side, the vote by which this bill was passed be reconsidered. And Senator Carroll moves to Table the motion of Senator Johns. All in favor of the motion of Senator Carroll will signify by saying aye. Opposed. The ayes have it and Senator Carroll's motion prevails. SB 1049 is declared passed. Next bill will be SB 1050, the Secretary will read it a 3rd time by title.

SECRETARY:

SB 1050 (Secretary reads title of bill). 3rd reading of the bill.

PRESIDING OFFICER (SENATOR GRAHAM):

Senator Wooten.

SENATOR WOOTEN:

This bill goes a step further in amending the Medical Practices Act relating to abortion. It ... what it does is say that the performance of an elective abortion, that is one consented to by the woman and the doctor, may only be done in a hospital, an ambulatory-surgical treatment center, or in such facilities supported by the State, the Federal government, a university or college. Now, there are two amendments to this. I was a little worried about the language in line 20 and 21 on page 1. The bill

originally said performance of an elective abortion except in the case of an emergency. We're back to that problem of dealing with what is an emergency. I had that language stricken from the bill, because I have what I think is a legitimate fear that emergency could be so widely interpreted that we could in effect keep the kitchen abortions going because someone could claim it was an emergency. We have also added an amendment to permit fee splitting. This comes from experience in New York where reports are that some abortion referral agencies will split fees with doctors. I think it is on the face of it unethical behavior and we have moved in the amendment to counteract that. This bill is perhaps the simplest, most straightforward of all three. I'd be happy to answer any questions.

PRESIDING OFFICER (SENATOR GRAHAM):

Any discussion? Senator Berning.

SENATOR BERNING:

Senator Wooten, I seem to have two amendments that were distributed, but I only have one as having been adopted. Where do we stand on this?

PRESIDING OFFICER (SENATOR GRAHAM):

Senator Wooten.

SENATOR WOOTEN:

I believe both should have been adopted. Is that the record?

PRESIDING OFFICER (SENATOR GRAHAM):

We'll check the record. Senator Berning, the Secretary indicates there were two amendments adopted. One in committee and one from the Floor. Any further discussion? Question ... Senator Shapiro.

SENATOR SHAPIRO:

Mr. President, I'm wondering if the sponsor will yield to a question?

PRESIDING OFFICER (SENATOR GRAHAM):

He indicates that he will.

SENATOR SHAPIRO:

Senator Wooten, the ... first bill now established standards and that's for hospitals, and would this second bill designate other facilities that could be regulated beyond the hospital?

PRESIDING OFFICER (SENATOR GRAHAM):

Senator Wooten.

SENATOR WOOTEN:

Yes, and this is the subject of SB 1051, the ambulatory-surgical treatment center. According to this ... to this bill abortions could only be performed in those two places. Now, let me explain the reasoning for that. Dealing in the first bill about all we could say was that abortions must be performed by physicians and then setting forth some limitations by second and third trimester. But we attempt to take this a step further to insure that all abortions are done in hospitals or ambulatory-surgical treatment centers. This is extremely important and I think we'll outline it in greater detail when we get down to 1051, because while an abortion can be a relatively simple operation, at least one fatality has occurred within the last two weeks of a woman who hemorrhaged after receiving an abortion and died before she could receive proper care. Although it appears to be a simple operation, it isn't. And you must have adequate safeguards and we attempt to put these into the medical practices act. And I imagine doctors and hospital associations will have their own regulations relative to this. The important thing is to put all kinds of safeguards around this procedure.

PRESIDING OFFICER (SENATOR GRAHAM):

Senator Shapiro.

SENATOR SHAPIRO:

One further question then. Then without ... these two bills, the second and third bill in the series, then these so-called clinics could continue to operate. Because the first bill does not set any standards for the operation of a clinic beyond the reach of a hospital. I [sic] that correct?

PRESIDING OFFICER (SENATOR GRAHAM):

Senator Wooten.

SENATOR WOOTEN:

That's exactly correct.

PRESIDING OFFICER (SENATOR GRAHAM):

Senator Sours.

SENATOR SOURS:

I ... I probably ought to explain Mr. President, Senators, to the other members of the Chamber that there was a problem and there still is with reference to the expense. Now, statistically I believe we can believe that the ... the indigent we'll call them the poor people, have more abortions than others. Now, to put them into a hospital at $200 a day or more, with all the tests and all that, would be creating a situation where the State would ultimately have to pick up the entire tab in many cases. Now, I think as the time goes on we ought to find some way other than hospitals, maybe the ambulatory clinic might be the answer. But it doesn't do much good to fatten up the hospitals with a large number of abortion patients who cannot pay. So probably the next bill is a step in the right direction. And there ought to be other locations too. Because the State cannot afford to pick up all the tab on this.

Somewhere in the very economy of things the patients or the putative father in many cases ought to be put on the hook.

PRESIDING OFFICER (SENATOR GRAHAM):

Senator Wooten. Any further discussion? Senator Berning.

SENATOR BERNING:

May I just ask for a definition of an ambulatory-surgical treatment center? Is it something like a check cashing piece of equipment?

PRESIDING OFFICER (SENATOR GRAHAM):

Senator Wooten.

SENATOR WOOTEN:

Well, that's the problem with having to do it in three bills Senator. Each bill deals with a separate item, and the third bill has to do with the ambulatory-surgical treatment center, which is a center for the performance of minor surgery that does not require an overnight stay. This by the way is an attempt to attack the very problem alluded to by Senator Sours, the tremendous expense of a hospital stay. Such centers are not limited to abortions. They can do all sorts of minor surgery, but I think the proper place to discuss that is in 1051. It is awkward to have it referred to in 1050, but I don't know how else to get around it.

PRESIDING OFFICER (SENATOR GRAHAM):

Chair might observe that 1050 is the one under discussion. Any further discussion? The question is shall SB 1050 pass. On that question the Secretary will call the roll.

SECRETARY:

Bartulis, Bell, Berning, Bruce, Buzbee, Carroll, Chew, Clarke, Conolly, Course, Daley, Davidson, Donnewald, Dougherty, Fawell, Glass,

Graham, Harber Hall, Kenneth Hall, Hynes, Johns, Keegan, Knuepfer, Knuppel,

PRESIDING OFFICER (SENATOR GRAHAM):

Senator Knuppel.

SENATOR KNUPPEL:

Mr. President and Members of this Body. I feel that I have to explain my vote because I stand here today with a very, very, very heavy heart. I think we're taking about something that to me is morally repulsive, abortion at any stage, because philosophically I can find life commences at only [one] time, and that's conception. Sure, the Supreme Court has said it's all right. I don't think if the Supreme Court legalized murder that I would think it was all right. I don't think it's in keeping with the moral fibers that this country has known since its inception, that it's a Christian nation, and to just make it easy to give a clinical atmosphere in which to commit murder whether it's with a gun, a knife, or a button hook, I cannot be a part of it. Too many people, friends, neighbors and others who I know were conceived ...

SENATE DATE: June 1, 1973

The question is shall SB 1021 pass. And on that question the Secretary will call the roll.

SECRETARY:

Bartulis, Bell, Berning, Bruce, Buzbee, Carroll, Chew, Clarke, Conolly, Course, Daley, Davidson, Donnewald, Dougherty, Fawell, Glass, Graham, Harber Hall, Kenneth Hall, Hynes, Johns, Keegan, Knuepfer, Knuppel, Kosinski, Latherow, McBroom, McCarthy, Merritt, Mitchler, Howard Mohr, Don Moore, Netsch, Newhouse, Nimrod, Nudelman, Ozinga, Palmer, Partee, Regner, Rock, Roe, Romano, Saperstein, Savickas, Schaffer, Scholl, Shapiro, Smith, Sommer, Soper, Sours, Swinarski, Vadalabene, Walker, Weaver, Welsh, Wooten, Mr. President.

PRESIDING OFFICER (SENATOR MOHR):

Mitchler, aye. Ozinga, aye. Graham, aye. Daley, aye. Latherow, aye. On that question the ayes are forty-six, the nays are none. SB 1021 having received the constitutional majority is declared passed. We have asked Senator Daley to hold SB 1020, and we will get back to that. SB 1050, Senator Wooten.

SECRETARY:

SB 1050 (Secretary reads title of bill). 3rd reading of the bill.

PRESIDING OFFICER (SENATOR MOHR):

Senator Wooten.

SENATOR WOOTEN:

Mr. President and colleagues. We have already discussed this bill at some length and I wish to express my thanks now. I forgot to last time, for really the

bipartisan support I have, both from President Harris, our Minority Leader, Senator Partee and for the eloquence of Senator Sours speaking in behalf of this bill. I'd like to mention once again really the most salient point of the bill. We passed SB 1049 which changes the law relative to abortions to bring Illinois statutes into line with the decision of the Supreme Court. However much some of us may disagree with that decision, I felt it was a necessary step. What we are left with is the Medical Practices Act which provides for the loss of license and standing as a physician if an abortion is performed. We'd like to change that language and substitute language saying where abortions can be performed. This is a bill requested by the Medical Society. They would like their ... their regulations by law to be brought in line with the Supreme Court's decision. I might mention by the way the Chicago Board of Health has passed a series of regulations relating to the places where abortions can be performed and so on. But 1050 is I think a very simple bill, it merely says that abortions must be performed in a hospital or a facility that is specially licensed to perform minor surgery that does not require an overnight stay. I might mention that the effect of this and regulations in the Medical Society would be to place the whole operation under fairly strict controls. And, as I told you before my concern was not only for the health of the mother, but what I think is a developing interest the State has in the unborn child. I've also amended this to forbid fee splitting which turns out to be a very unhappy practice that has occurred in New York between abortion referral clinics and abortion clinics. So, it simply makes that statement that abortions must be done in a

hospital. Of course, that's true by the way for the last six months regardless, it must be in a hospital. But in the first trimester they must be done in a hospital or in a very specially licensed clinic that is under very strict control. As I say, I thank those Senators on both sides of the aisle who've supported this and already spoken in its behalf. And I'd ask for a favorable roll call.

PRESIDING OFFICER (SENATOR MOHR):

Any further discussion? The ... Senator Knuppel.

SENATOR KNUPPEL:

I talked against this bill the other day, and I'm not going to waste a lot of time today, it's not any better today than it was the other day. And an abortion, particularly in the second trimester is not minor surgery.

PRESIDING OFFICER (SENATOR MOHR):

Senator Wooten.

SENATOR WOOTEN:

This has no relation to the second trimester.

PRESIDING OFFICER (SENATOR MOHR):

The question is shall SB 1050 pass. And on that question the Secretary will call the roll.

SECRETARY:

Bartulis, Bell, Berning, Bruce, Buzbee, Carroll, Chew, Clarke, Conolly, Course, Daley, Davidson, Donnewald, Dougherty, Fawell, Glass, Graham, Harber Hall, Kenneth Hall, Hynes, Johns, Keegan, Knuepfer, Knuppel, Kosinski, Latherow, McBroom, McCarthy, Merritt, Mitchler, Howard Mohr, Don Moore, Netsch, Newhouse, Nimrod, Nudelman, Ozinga, Palmer, Partee, Regner, Rock, Roe, Romano, Saperstein, Savickas, Schaffer, Scholl, Shapiro, Smith, Sommer, Soper, Sours.

PRESIDING OFFICER (SENATOR MOHR):

Senator Sours. We'll let you talk this time, but we're going to remind you and all the Senators that there's no explanation of votes as of today.

SENATOR SOURS:

Well, all right.

PRESIDING OFFICER (SENATOR MOHR):

We will grant you leave ...

SENATOR SOURS:

I vote aye. I vote aye.

PRESIDING OFFICER (SENATOR MOHR):

....this time. Aye.

SECRETARY:

Swinarski, Vadalabene, Walker, Weaver, Welsh, Wooten, Mr. President.

PRESIDING OFFICER (SENATOR MOHR):

Mitchler, aye. Bell, present. Clarke, aye. Request to call the absentees.

SECRETARY:

Bartulis, Chew, Clarke, Daley, Donnewald, Dougherty, Fawell, Kenneth Hall, Hynes, Keegan, Kosinski, McCarthy, Merritt, Nimrod, Nudelman, Palmer, Rock, Romano, Smith, Sommer, Walker, Welsh.

PRESIDING OFFICER (SENATOR MOHR):

Senator Palmer, On that ... on that question the yeas are thirty-one, the nays are ten, one voting present. SB 1050 having received a constitutional majority is declared passed. SB 1051, Senator Wooten.

SECRETARY:

SB 1051 (Secretary reads title of bill). 3rd reading of the bill.

PRESIDING OFFICER (SENATOR MOHR):

Senator Wooten.

SENATOR WOOTEN:

Thank you, Mr. President. This is another one of those bills that cuts across lines in all kinds of ways. The Illinois State Medical Society asked that it be presented in a series with the two previous bills, one changing the law relating to abortion, the other changing the Medical Practices Act. While this has a relationship to abortion, it actually goes much beyond that. It provides for the establishment and licensing of facilities which can perform minor surgery. This would be things like tonsillectomy, hernias, abortions would be included, facial surgery, plastic surgery and so on. In other words procedures which would not require an overnight stay. And indeed these ambulatory surgical treatment centers are forbidden to keep patients overnight. However, those of you who have kept close to medical practices know that untoward things can occur at any time, and so provision is made in here that doctors who function in such a center must also be licensed to practice in a hospital nearby so that if any complications occur they can quickly move the patient to that place. Now, I handed out an outline to explain to you how these things would work, definitions, they must get a license, some of these things are left open as to regulations. The Department would like to take a hand in that. This is something doctors have been urging us to do for a couple of years now, and ambulatory surgical treatment centers are ... are in effect out west. The idea is they can be a great saving to a patient. One of the big costs in a hospital, if you remember it's kind of like a hotel which has special services. And if you

don't need that overnight stay, you can save a great deal of money. So there's a great savings possible for the patient who needs this kind of a one-day surgical treatment. It does include abortion, and everything would be rather closely regulated and inspected. I'll be glad to answer any questions I can on this.

PRESIDING OFFICER (SENATOR MOHR):

Senator Knuppel.

SENATOR KNUPPEL:

Mr. President, I'd like to ask the sponsor a question if he'll yield.

PRESIDING OFFICER (SENATOR MOHR):

He indicates he will.

SENATOR KNUPPEL:

Senator Wooten, you relate this to abortions. I've read this bill and I don't find where abortion is mentioned in here anywhere.

PRESIDING OFFICER (SENATOR MOHR):

Senator Wooten.

SENATOR WOOTEN:

Actually, it is one of the procedures that would be possible. I must point out though that in bill 1049, that in 1049 such a center like a hospital is free to refuse to do abortions.

PRESIDING OFFICER (SENATOR MOHR):

Senator Knuppel.

SENATOR KNUPPEL:

This ... this bill is a good bill. It's not related in any way to abortions. It's sponsored by the Medical Association. There's nothing wrong with ambulatory medical services. The question of abortion is a moral one as far as I'm concerned. I can support this bill, because it doesn't mention abortion. And I don't understand how or why anybody would relate it

to abortions. If somebody wants to have an abortion and they want to go there, that's their business. But there's isn't ... the word abortion isn't mentioned in this act anywhere, and it has no relation to it.

PRESIDING OFFICER (SENATOR MOHR):

Senator Ozinga.

SENATOR OZINGA:

Mr. President, this is a good example of ... you give them an inch, they want a mile. Now, right off the bat, you have just voted on allowing abortions in Illinois. Ok, so we're opening the door wide open already by having an ambulatory services come right to the door, if you need it. This is ridiculous. If you ... created or associate with anything you want, morality or anything else you want. It's part of the abortion series. Let's face it, this bill should be defeated along with all the rest of them.

PRESIDING OFFICER (SENATOR MOHR):

Senator Wooten may close the debate.

SENATOR WOOTEN:

In responding to Senator Ozinga, I'm afraid you've misstated the situation Senator. We did not do anything in any of these series of bills to permit abortion. That has been done by the Supreme Court. All we have done is change language to bring our Illinois statutes in line with the Supreme Court. We really don't change the law ... the practical effect of the law one way or the other. The only reason this is here, and I question the Medical Society about the good sense of putting it in this series. I did not think, strictly speaking it belonged here. But you see, just as a hospital can perform an abortion, if it so chooses, so could such a treatment center. The main thrust of this is to try to save some money by getting minor surgical

treatment out of the hospital where it is hideously expensive and into a clinic. I shouldn't call it a clinic because it's far more than that. It has life support facilities available. And, I might further add, as I say, I don't like to bring the subject of abortion really too close to this, because as Senator Knuppel says it really goes beyond it. This would only affect this particular surgery-center they're called in other parts of the country in the first trimester anyway. They could not participate in abortions in the last six months. Absolutely forbidden by the legislation we just passed.

PRESIDING OFFICER (SENATOR MOHR):

The question is shall SB 1051 pass. And on that question the Secretary will call the roll.

SECRETARY:

Bartulis, Bell, Berning, Bruce, Buzbee, Carroll, Chew, Clarke, Conolly, Course, Daley, Davidson, Donnewald, Dougherty, Fawell, Glass, Graham, Harber Hall, Kenneth Hall, Hynes, Johns, Keegan, Knuepfer, Knuppel, Kosinski, Latherow, McBroom, McCarthy, Merritt, Mitchler, Howard Mohr, Don Moore, Netsch, Newhouse, Nimrod, Nudelman, Ozinga, Palmer, Partee, Regner, Rock, Roe, Romano, Saperstein, Savickas, Schaffer, Scholl, Shapiro, Smith, Sommer, Soper, Sours, Swinarski, Vadalabene, Walker, Weaver, Welsh, Wooten, Mr. President.

PRESIDING OFFICER (SENATOR MOHR):

Request to call the absentees.

SECRETARY:

Bartulis, Bell, Chew, Clarke, Conolly, Course, Daley, Dougherty, Harber Hall, Kenneth Hall, Hynes, Keegan, Kosinski, McBroom, McCarthy, Howard Mohr, Nimrod, Nudelman,

Palmer, Rock, Romano, Shapiro, Smith, Sommer, Soper, Vadalabene, Welsh.

PRESIDING OFFICER (SENATOR MOHR):

Clarke, aye. On that question the yeas are thirty, the nays are six, one having voted present. SB 1051 having received the constitutional majority is declared passed. SB 1052, Senator Hynes.

HOUSE DATE: June 28, 1973

Telcser:	"Amendments from the floor."
Jack O'Brien:	"Amendment #1, Kucharski. Amends Senate Bill 1049..."
Telcser:	"The Gentleman from Cook, Representative Kucharski."
Kucharski:	"Leave, leave to table Amendment #1."
Telcser:	"The Gentleman moves to table Amendment #1. All those in favor say 'aye', opposed 'no'. The Amendment's adopted. The table, the Gentleman's motion is successful and the Amendments are, is tabled. Now are there further Amendments. The Bill is advanced to the order of Third Reading."
Jack O'Brien:	"Senate Bill 1050, Day. A Bill for an Act to amend the Medical Practice Act. Second Reading of the Bill. No Committee Amendments."
Miller:	"Are there any Amendments from the floor? Third Reading."
Jack O'Brien:	"Senate Bill 1051, Day. A Bill for an Act relating to Ambulatory Surgical Treatment Centers. Second Reading of the Bill. No Committee Amendments."
Miller:	"Are there any Amendments from the floor?"
Jack O'Brien:	"Amendment #1, Matijevich. Amends Senate Bill 1051 on page 4, line 33 by inserting after..."

Miller: "The Gentleman from Cook, Mr. Matijevich."

Matijevich: "Mr. Chairman and Members of the House, I have two ah ... Amendments to House, er ... Senate Bill 1051 and I want the Membership to know that these Amendments I want the Membership to completely divorce the issue of these Amendments from the abortion issue. Ah ... I think, however, as long as we are ah ... establishing Ambulatory Surgical Treatment Centers that we ought to proceed properly. Now Amendment #1 under Section 6 ah ... we include the authority to issue provisional licenses for Ambulatory Surgical Treatment Centers which do not comply with provisions of the Act provided that the Director finds that such Center will undertake changes and corrections to comply. What my Amendment does, it specifies that the period for the provisional license shall not exceed one year and such license may be renewed only once and I think this is proper if we are going to have provisional licenses, let's put a limit ah ... on the date, how long the provisional license shall be for and allow only one extension of that provisional license. In other words, ah ... a year and one extension gives

enough time for someone to comply with the standards set up by the Department and I think it's a good Amendment since we are establishing these new ambulatory facilities. I move the adoption of Senate, ah ... Amendment #1 to Senate Bill 1051."

Miller: "Is there discussion? The Gentleman from Peoria, Mr. Day."

Day: "Well, Mr. Speaker and Ladies and Gentlemen of the House, I rise to oppose this Amendment primarily because this is a very important piece of legislation. There are abortion clinics now operating in this State. They are advertising in the newspapers. It is of the utmost importance that the Legislature enact a Bill licensing these facilities. I am afraid that if this Bill goes back to the Senate, it may get lost in the shuffle and we may not have any licensing authority on the part of the State of Illinois if this Bill is not adopted. Now the present Bill in its present form does permit, does permit the issuance of a provisional license if the problem is a minor one and if the Department finds that the health and safety of the patients will be protected during the period for which the provisional license is granted. Ordinarily I would have no objection to this Amendment. I think there is

some merit to it, but I do not think it is important enough to take the chance on losing this Bill altogether. The risk is too great at this stage in the Legislative Session and for these reasons, I would urge the Members of the House to reject this Amendment and to vote red."

Miller: "The Gentleman from Lake, Mr. Pierce who is in Mr. Choate's seat."

Pierce: "Ah ... Would the Sponsor of the Amendment yield to a question?"

Miller: "Proceed, sir."

Pierce: "Representative Matijevich, has the Department of Public Health taken a stand in favor of this Amendment?"

Matijevich: "I really don't know. I've had the Amendment ah ... published for some time and I really don't know what stand they take ah ... I brought up this Amendment after discussing with the Democratic staff of the Human Resources Committee ah ... both his feeling and my feeling that as long as we are ah ... setting up new facilities and we provide for a provisional license that we give them a certain period of time and..."

Pierce: "You've answered my question. I know the purpose of the Bill and I agree with Representative Day that the purpose may be all right, but it would seem to me that rather than just

discussing with the staff, ah ... at this late date, it maybe should have been discussed with the Department of Public Health to determine their position on the Amendment and in absence and just speaking for myself in absence of their approval, ah ... of the Amendment, I tend to agree with Representative Day that it's a little late now to try to amend such a serious matter without having cleared it with the Department of Public Health which is advancing these Bills from the Senate to ah ... to begin with. So ah ... speaking only for myself, ah ... I intend to oppose the Amendment because it hasn't been cleared with the sponsoring Department of this legislation."

Matijevich: "Well, I can answer that now. I talked to the Members of staff who I worked this with ah ... and they, the Department of Public Health thinks it's a good Amendment. They want no Amendment because as Representative Day said that they think maybe the Bill would be in trouble. My position is and I had no ah ... I wasn't aware of [how] the Department of Public Health felt. They get paid enough to look at all the legislation as far as I'm concerned. I don't have to run around looking for them, but ah ... ah ... my position is

that it's a good Amendment and I think Amendment #2 is good and I think it strengthens the Bill and ah ... for that reason, I would ask the adoption of Amendment #2. The Department of Public Health thinks it's a good Amendment. I can't see the Senate not concurring with an Amendment that is a good Amendment. I really think that they would support it."

Miller: "The Gentleman from Cook, Mr. McPartlin."

McPartlin: "Mr. Speaker and Members of the House, I think this is a good Amendment as far as provisional licensing is concerned not to exceed a year. I think it, it tightens up the ah ... the standards, the regulations, the rules that they have to work under and I would be for this Amendment."

Miller: "The Gentleman from Cook, Mr. B.B. Wolfe."

Wolfe: "Mr. Speaker and Ladies and Gentlemen of the House, I'm sure that our colleague was motivated ah ... with good intent on this particular Amendment, but I was informed yesterday ah ... by Representatives of the Department of Public Health that they don't even intend to go beyond 60 days with a provisional license under their rules. They just want time enough to make a

personal inspection of each facility ah ... under its temporary license and then to determine whether or not that facility is complying with its presents [sic] rules and regulations and then either terminate the provisional license or if they qualify, give them a permanent license. So in reality, the Amendment is really not necessary at this time. If we feel at a later date that the Department is not ah ... utilizing its best investigative procedures, we can ah ... introduce legislation to correct that defect and I would oppose the Amendment at this time for that reason among some of the other reasons stated by our colleagues."

Miller: "The Gentleman from Cook, Mr. R.L. Dunne."

Dunne: "Well, I'd like to ask a question of the Sponsor and if I may, I'd really like to query, kind of, my question is addressed to this Bill and also 1049 and 1050 ah ... that did advance. There are three related Bills. First of all, ah ... has there been a change in Sponsorship in the Senate, Mr. Day?"

Miller: "Mr. Day, from Peoria, care to answer."

Day: "Well, the ah ... the Sponsorship of this Bill is ah ... in the Senate to my knowledge is indicated by the Calendar. Ah ... I think that ah ...

Senator Wooten did have a important part in ah ... advancing this Bill in the Senate, but ah ... as I look at it now, it appears to be Sponsored by Senator Rock."

Dunne: "Well, I think that's probably a significant, very significant factor that a lot of the Members of this House will realize that this ah ... these Bills while they were originated and steered through the House by Senator Wooten, ah ... they now have the Sponsorship of Senator Rock. I have one more question with respect to this Bill. Ah ... Does it have any ah ... restriction now in the Bill with respect to ah ... a time lag from when a woman ah ... is interviewed or first examined for an abortion and when the actual abortion is performed?"

Miller: "Ah ... Points of order are being raised, the question now is on Amendment #1."

Dunne: "Well, my point, Mr. Speaker, is that I, without having an opportunity to examine this Bill I am concerned about it getting to Third without being in the shape at least I'd like to see it in. So if, if, you'd allow that question to be answered, I'd appreciate it."

Miller: "Mr. Matijevich care to answer. Perfectly agreeable with the Chair."

Matijevich: "Mr. Chairman, I was going to raise the point of order that he wasn't speaking to the Amendment. Now I have no control, I'm just trying to adopt two Amendments which I think are good for the Bill. I have no control over the Bill. You'd have to discuss that with the Representative Day."

Miller: "Go ahead, Mr. Dunne."

Dunne: "May I have the leave, though, to after this Amendment is, is discussed and voted up or down before the Bill is advanced, could I perhaps have that question answered. Would that be in order?"

Miller: "Well, the Chair is of the opinion that the type of thing that you're discussing is something that would normally be discussed when the Bill is on Third Reading, Mr. Dunne, not on the discussing of Amendment 1. All right, the Gentleman from Lake, Mr. Matijevich, to close."

Matijevich: "I'll say only quickly that under the Act as drafted here, we call for provisional licenses with no limitation as to time and all I'm trying to do is put a limitation and I think that's good. I know the Department of Mental ah ... the Department of Public Health now supports that except they're worried about whether the Bill is passed. I think if you're

trying to pass a Bill, pass a good one. I ask for your adoption Amendment #1 to Senate Bill 1051."

Miller: "All right, the Gentleman from Lake has moved the adoption of Amendment #1. All those in favor say 'aye', opposed 'no'. The 'nays' appear to have it. All right and the Gentleman's ah ... ah ... Amendment #1 fails. It's not adopted. Are there further Amendments?"

Jack O'Brien: "Amendment #2, Matijevich. Amends Senate Bill 1051 on page 8 by deleting all of line..."

Miller: "The Gentleman from Lake, Mr. Matijevich."

Matijevich: "Mr. Chairman, in the interest of time ah ... I think I know what would happen. I'll tell the Membership what I wanted to do with Amendment #2. ah ... I wanted the State, the Comprehensive State Health Planning Agency to review and comment ah ... on the facilities that may be established ah ... so that they at least come within the comprehensive state health plan. I think this is good. I don't want to take up the time of the House because I know what will happen, but I think that after this becomes law, that both Amendment #1 and Amendment #2 ah ... ought to be ah ... implemented

through new legislation. So I will withdraw Amendment #2."

Miller: "The Gentlemen moves that Amendment #2 be tabled. All those in favor say 'aye', opposed 'no'. The 'ayes' have it. The Amendment is tabled. Are there further Amendments?"

Fred Selcke: "Amendment #3, Douglas. Amends Senate Bill 1051 on page 4, line 33 and so forth."

Miller: "Mr. Douglas moves that Amendment #3 be tabled. All in favor say 'aye', opposed 'nay'. The 'ayes' have it. The Amendment's tabled. Are there further Amendments? The Bill is advanced to the order of Third Reading. Call the next Bill, Mr. Clerk."

HOUSE DATE: July 1, 1973

Page	Time	Speaker	Information
		Clerk Selcke	Reads Senate Bill 1049
		Speaker Telcser	
		Day	Leave to consider companion Bills 1049, 1050 and 1051 (Senate)
		Speaker Telcser	
		Day	Repeats request
106		Speaker Telcser	
		Clerk Selcke	
		Speaker Telscer	
		Clerk Selcke	
		Speaker Telscer)	
		)	
		Dunne, R)	Question
		Clerk Selke	Reads Senate Bill 1050

	Speaker Telcser	
107	Day	Explains the Senate Bills
	Speaker Telcser	
108	Hyde	Explains 'aye' vote
	Speaker Telcser	
109	Hudson	Explains opinion

["]So I think we should vote 'aye' on this Bill, on this Conference Committee Report and ... ah ... be sure we don't lose any others that may be floating around the rotunda so that we can adjourn very shortly. I vote 'aye'."

Speaker Blair: "The Gentleman from Winnebago, Mr. Simms."

Sims: "Ah ... Mr. Speaker in explaining my vote I'd like to stress the urgency that this legislation does receive the necessary votes ah ... for all the benefit of the people. A good deal of time and energy has been put into this. It's excellent legislation. Let's vote on it's merits and concur. Thank you."

Speaker Blair: "All right. Have all voted who wish? The clerk will take the record. On this question there are 110 'ayes' and 26 'nays' and the House adopts the Conference Committee Report with the respect to ... ah ... House Bill 1133. Senate Bill 192. Murphy. The Gentleman from Lake, Mr. Murphy. Go ahead Mr. Murphy. Can you explain?"

Murphy: "Ah ... Mr. Speaker I move that this House do adopt the Conference Committee Report on Senate Bill 192."

Speaker Blair: "All right is there discussion? The question is shall the House adopt the Conference Committee Report with respect to Senate Bill 192? All those in favor vote 'aye', the opposed 'no'. Final action requires 107 votes. Have all voted who wish? The clerk will take the record. Choate 'aye' and Barry 'aye'. Maragos 'aye' and the rest of you please come up please. On this question there are 112 'ayes' and 3 'nays' and the House adopts the Conference Committee Report with respect to Senate Bill 192. Now ... ah ... is Jake back there? All right Senate Bills, Third Reading. Senate Bill 1049."

Fredric Selcke: "Senate Bill 1049. Third Reading of the Bill."

Telcser: "Gentleman from Peoria, Representative Day."

Day: "Well, Mr. Speaker and Ladies and Gentlemen of the House, this time I would ask leave to consider Senate Bills 1049, 1050 and 1051 as Companion Bills."

Telcser: "What did he ask for leave? Are there any objections?"

Day: "Leave to consider 1049, 50 and 51 as Companion Bills."

Telcser: "Will the Clerk please read ... ah ... Senate Bill 1049, 50 ... Representative R. L. Dunne, for what purpose do you arise, Sir?"

Fredric Selcke: "Ah ... Senate Bill..."

Telcser: "What ... what ... right here, Mr. Electrician."

Fredric Selcke: "1050."

Telcser: "One second please. Representative R. L. Dunne is objecting. Will the electrician turn him on? Go ahead, Bob."

Dunne: "Well, I ... I've been looking at these Bills for quite some time and I does this mean we'll be voting on them on one Roll Call for the three Bills?"

Telcser: "Yes, we will take one Roll Call and the Clerk would make sufficient number of copies for the Journal."

Dunne: "But separate Roll Calls will be....?"

Telcser: "Yeah. If you want to get change certainly. Will you read the Bills, Mr. Clerk? The Clerk will you read the other Bills please?"

Fredric Selcke: "Senate Bill 1050, an Act to amend the Medical Practice Act. Third Reading of the Bill. Senate Bill 1051, an Act relating to specialized and regulations of Ambulatory Surgical Treatment Centers. Third Reading of the Bill."

Telcser: "The Gentleman from Peoria, Representative Day."

Day: "Mr. Speaker and Ladies and Gentlemen of the House, the Bills are interrelated in the sense that they, to some extent, all deal with the subject of abortions. These are the only Bills still alive in this Session which regulate this controversial subject.

The first Bill, Senate Bill 1049, as I would say is the main Bill, and it proscribes regulations for the performance of abortions in the State of Illinois. The all three of these Bills ... ah ... are approved by the Illinois Medical Association, the Illinois Hospital Association and the Illinois Department of Public Health. Senate Bill 1049 follows the guidelines set down by the Supreme Court in the Georgia Case and in the Texas [case] and it provides, briefly, that during the first trimester, an abortion can be performed only by a physician. In the second trimester, only by a physician in a hospital with life-support facilities available and used if fetus is viable. In the third trimester, only to preserve the physical or mental health of the mother after consultation with two other physicians. Section VI contains a Conscience Clause which would prohibit any kind of action being taken against any hospital employee, or any other employee who because of reasons of conscience, refused to take part in an abortion ... ah ... Section VII has a Penalty Clause and provides that anyone who commits a criminal abortion shall be guilty of a Class II felony ... ah ... Section VIII of the

Bill ... ah ... contains prohibitions against ... ah ... experimentation with the fetus. Ah ... the Bill, like the other two Bills ... ah ... provides that it will become effective when it becomes law. Now the second Bill, Senate Bill 1050, simply limits the places where an abortion can be performed and if the limitations are that it can be performed, of course, in a hospital or in an Ambulatory Surgical Treatment Center, in a State Hospital or Surgi-Center, in a Federal Hospital or Surgi-Center or in a University Hospital or Surgi-Center. So with this Bill, with 1050, we will limit ... ah ... abortions to those facilities. Now the last Bill which is Senate Bill 1051, is a Licensing Bill which licenses Ambulatory Surgical Treatment Centers and when we use the word, 'Ambulatory' here, of course, it refers to patients who are able to walk in and walk out of the Treatment Center ... ah ... and specifically provides that there shall be no ... ah ... overnight facilities or pet facilities for patients ... ah ... this Bill is not limited to ... ah ... the matter of abortions, but it would include such things as Oral Surgery or very minor operations or ... ah ... stitching in case ... ah ... someone needs a few stitches and it fairly sets

up stringent regulations for the licensing of these facilities. It provides that they must be operated under the medical supervision of a physician and that if surgery is performed by a doctor, it must be by a doctor who can admit a patient to a hospital if complications arise. Contains very strict ... ah ... regulations for the licensing of these Ambulatory Surgical Treatment Centers ... ah ... I'd be happy to answer any questions."

Telcser: "All right the Gentleman from Cook, Representative Hyde."

Hyde: "Well I have no questions ... ah ... Mr. Speaker and Ladies and Gentlemen of the House. I know what these Bills do and ... ah ... I am going to support them ... ah ... with the extremist reluctance that I can muster because I abhore the very bloody ... ah ... sorry practice of taking a human life, simply because it's inconvenient, simply because it's unwanted but I know that the Supreme Court has saddled this Country with a decision that ... ah ... renders a human life subordinate to that of ... ah ... ah ... of animal life really ... ah ... and we are going to have abortions in this State as a result of that ... ah ... decision. And it seems to me that ... ah ... we must

make the best of a very sorry situation by at least regulating that procedure so that the Abortion Mills will not proliferate so that ... ah ... the ... ah ... Abortionists who are going to get wealthy very quickly ... ah ... running from cubicle to cubicle terminating human lives for two or three hundred dollars or thirty pieces of silver as the case may be so that this sorry process may at least be in antiseptic surroundings. And so without conceding one inch, without conceding one inch that this proceeding is proper, that it's decent ... ah ... I'm going to vote to regulate it in the State of Illinois in the hopes that the United States Supreme Court will some day soon take another look at this situation and recognize that the simple process of being born is simply a change of address from the mother's womb into the outside world and that a living, breathing human being exists in the mother's womb waiting only to be born and so I will vote 'yes' for these Bills ... ah ... only for the reason that they are going to regulate this medical process and possibly save unfortunate women who are seeking abortions from infection and possible death ... ah ... in the improper surroundings. And so with that statement and

reserving certainly the right to continue to fight for the ... ah ... prohibition of abortion, to continue to fight for the right to life for that most innocent ... ah ... and most inconvenient of human beings, the unborn,... ah ... I will vote 'yes' for these Bills. Thank you."

Telcser: "The question is shall these Bills pass? All those in favor signify by voting 'aye', the opposed by voting 'no'. Representative Hudson, to explain his vote, Gentleman from DuPage, Mr...."

Hudson: ["]Mr. Mr. Speaker what I really wanted to do is ask a question. I don't want to take the ... it is too late. I know it's too late. I don't want to take the time of the House but I am going to ... ah ... say this much and I guess we can call it an explanation of my vote but I have a clipping from a newspaper here in front of me. A couple of days ago one of our large metropolitan newspapers and these are advertise ... advertisements for abortions. Abortion Up To Twelve Weeks — Lo Cost. This is one, Licensed Physicians. Who they might be I don't know. Superior Facilities, etc. You've all seen these. Another ad, Abortions, Pregnancy Tests, and so forth ... ah Clinic and Hospital is another one. Abortion

Bureau Center — One Low Price Includes Everything. God knows what that means: Includes Everything. I don't know. I can only hope that if this Bill passes that ... ah ... some of the abuses that I'm sure must be being perpetrated ... ah ... at this moment in this area would be remedied."

Telcser: "Have all voted? The Gentleman from Cook, Representative William Walsh."

Walsh, Wm.: "I'd like to be recorded as voting 'present', Mr. Speaker."

Telcser: "Record Representative Gibbs, William Walsh. There's a number of you. Why don't you come up here and tell the clerk? Gentleman from Cook, Representative Richard Walsh."

Walsh, Richard: "Mr. Speaker, Ladies and Gentlemen of the House, just briefly in explaining my vote I would like to point out that what we're doing here is reacting to a Supreme Court decision and House Bill 1059 specifically says an abortion may be performed under the following conditions and it enumerates the conditions. Now it hasn't been too long since we've seen the Supreme Court reverse itself in the area of reapportionment, in the area of pornography. They do it regularly. I

feel they'll see the light in this very important area that we're discussing today. I refuse to support these Bills and intend to be recorded as voting present."

Telcser: "Have all voted who wish? Gentleman from Cook, Representative Washington."

Washington: "Ah ... Mr. Speaker I regret doing this. I was off the floor and missed all of the debate, but if ... ah ... the Sponsor would care to respond in explaining his vote I would like to know two things. One ... ah ... what restrictions are there on the first trimester, and two as to the other Bill. What restrictions are there as to facilities, if he would be so kind?"

Telcser: "The Gentleman from Peoria, Representative Day."

Day: "Well Mr. Speaker and Ladies and Gentlemen of the House the restriction during the first trimester ... ah ... are limited to that of requiring that the service be performed by a physician and in the second Bill that it must be performed in a licensed facility."

Telcser: "O'kay now a number of you still want to explain we're ... we're beating this time something terribly. We're trying our best. I'll get B. B. Wolfe, but that means Merlo's Bill won't be called and Kempiners. The

Gentleman from Cook, Representative B. B. Wolfe."

Wolfe: "Thank you. Briefly Mr. Speaker in a large metropolitan newspaper just two days ago, the Sun-Times, an editorial consistent with the action of a colleague of this House that I stand here today to admire as a true lawmaker and in the true sense of the profession because this editorial said, 'we urge House Members, many of whom are violently opposed to the legislation ... legislation of abortion to view the measures not as pro-abortion Bills but as public health measures. That is what they are and they should be approved as such and I heartily endorse this package because it is the only one in the State of Illinois to carry out quality medicine in this area. Thank you."

Telcser: "Have all voted who wish? Take the record. Representative Lemke, for what purpose do you rise sir?"

Lemke: "To explain my vote. Could you please vote me 'no' on 1049 and 'yes' on the other two?"

Telcser: "Yes but you can all do that if you'd come to the clerk's desk and I'd be glad to do it. Representative Waddell for what purpose do you rise?"

Waddell: "I wish to be recorded 'present' so that it goes on the tape."

Telcser: "On this question 111 'ayes', 13 'nays' and these Bills having received the constitutional majority are hereby declared passed."

APPENDIX B

Standards

for Obstetric-Gynecologic Services

Seventh Edition

The American College of
Obstetricians and Gynecologists

Surgical Services

Certain surgical procedures may be performed in an ambulatory care facility to conserve time and expense for the patient and to make efficient use of hospital facilities. A physician's office, an outpatient clinic, or a free-standing or hospital-based ambulatory surgical facility may be used as the setting. Procedures should be limited to those that can be performed safely within the constraints of staff expertise and physical facilities. If the patient has a major medical disorder, the gynecologist should obtain appropriate consultation before proceeding with a surgical procedure in an ambulatory care facility.

Informed consent should be obtained before any surgical procedure is performed. Upon discharge, the patient should be given adequate, preferably written, postoperative instructions, and arrangements made for routine and emergency follow-up care. The importance of a follow-up evaluation should be stressed during both the preoperative and the postoperative interviews.

Removed tissue should be submitted to a pathologist for examination. Routine pathologic examination of tissue may not be necessary, however, following the elective termination of a pregnancy in which embryonic or fetal parts can be identified. In such instances, the physician should simply record a description of the gross products of conception. The patient should be informed of the operative findings, including the results of tissue examination.

Physician's Office and Outpatient Clinic (Excluding Ambulatory Surgical Centers)

Only those surgical procedures that can be performed either without anesthesia or with only local anesthesia may be

performed in the physician's office or in an outpatient clinic. When local anesthesia is used in these settings, equipment, drugs, and qualified personnel should be available for emergency resuscitation.

Procedures commonly performed in a physician's office or in an outpatient clinic include, but are not limited to, the following:

- Abortion, uncomplicated, up to 14 weeks from last menstrual period
- Aspiration of a breast cyst
- Biopsy, aspiration, or washing of the endometrium
- Cervical polypectomy
- Cervical, vaginal, and vulvar biopsies
- Colposcopy
- Cryosurgery, fulguration, or vaporization of the cervix or vulva
- Culdocentesis
- Cystometric studies
- Cystoscopy
- Dilation and curettage
- Evacuation of incomplete abortion, spontaneous and uncomplicated
- Hysterosalpingography
- Hysteroscopy
- Incision and drainage of vulvar or perineal abscesses
- Insertion of intrauterine contraceptive device
- Proctosigmoidoscopy
- Removal of skin lesions
- Tubal insufflation
- Urodynamic studies
- Uterine sounding

Free-Standing and Hospital-Based Facilities

Ambulatory surgical facilities that are free-standing or based in a hospital should maintain the same surgical, anesthetic, and personnel standards that hospitals do. In these facilities, surgical procedures may be performed under general or regional block anesthesia, but the postoperative recovery is expected to permit discharge on the same day. There should be a written policy providing for prompt emergency treatment or hospitalization of patients in the event of an unanticipated complication.

Procedures commonly performed in a free-standing or hospital-based ambulatory surgical facility include, but are not limited to, the following:

- Breast biopsy
- Cervical conization
- Colpotomy
- Examination under anesthesia
- Extensive biopsies or extensive fulgurations of vulvar lesions
- Laparoscopy for diagnostic studies, tubal sterilization, or other surgical procedures, if laparotomy is not anticipated
- Laser surgery
- Marsupialization of a Bartholin duct abscess or cyst
- Minilaparotomy for sterilization
- Simple perineoplasty

Those procedures that may be performed in the physician's office or the outpatient clinic may also be performed in free-standing or hospital-based facilities.

A qualified anesthesiologist, another qualified physician, or a certified nurse-anesthetist who is supervised by an anesthesiologist may administer general, epidural, or spinal anesthesia in an ambulatory surgical unit. When any form of anesthesia is used, trained personnel and proper equipment and drugs for cardiopulmonary resuscitation should be available. A physician, preferably the anesthesiologist, should be present in the ambulatory surgical facility until all patients have been discharged. This physician should oversee the postanesthetic recovery area and should share with the surgeon the responsibility for discharging patients or transferring them to the backup hospital.

Only patients at low risk should be considered candidates for ambulatory surgery. A preoperative history and physical examination should be completed no more than 2 weeks before the surgical procedure is to be performed. Preexisting or concurrent illness, medications, and adverse drug reactions that may have an effect on the operative procedure or anesthesia should be identified. Laboratory data should include hemoglobin level or hematocrit determination, urine screen, and in selected patients, other studies (eg. chest roentgenogram, electrocardiogram, and determination of electrolyte levels). The patient should be given preoperative instructions, especially regarding restrictions on food and fluid intake, and advised that noncompliance may result in cancellation of the procedure.

On the day of the surgery, a physician should perform a preanesthetic evaluation, including an interval history, medical record review, and heart and lung examination. The findings should be noted in the record.

Every free-standing or hospital-based ambulatory surgical facility should have a recovery area. During the recovery period, a member of the health care team should

observe the patient continuously. This person should maintain a complete record of the patient's general condition, including vital signs, blood loss, and occurrence of complications. The patient should remain in the area until recovery is sufficient to permit safe discharge in the company of a responsible adult. Upon discharge, the patient should be given instruction about medications, follow-up care, signs and symptoms of common complications, and procedures to obtain emergency care and advice.

Abortion

Ambulatory care facilities should meet the same standards of care for abortion services as for other surgical procedures. Physicians who perform abortions in their offices should provide for prompt emergency treatment or hospitalization of patients in the event that a complication occurs. Clinics and free-standing ambulatory care facilities should have a mechanism for the transfer of patients requiring emergency treatment to a nearby hospital.

Generally, abortions in the physician's office or outpatient clinic should be limited to those performed within 14 weeks from the first day of the last menstrual period. In a hospital-based or free-standing surgical facility, abortions should generally be limited to those performed within 18 weeks from the last menstrual period. In a hospital-based facility where surgical, recovery, and emergency response capabilities are comprehensive, however, abortions may be performed beyond this time.

Prior to the procedure, the woman should be counseled on the options for the management of an unwanted pregnancy. She should be allowed sufficient time for reflection before she makes an informed decision. If she has received counseling elsewhere, the physician who is to

perform the abortion should verify that the counseling has taken place.

In addition to the history, physical examination, and indicated laboratory procedures, Rh factor should be determined and an antibody screen performed on a woman who is to have an abortion. Every unsensitized Rh-negative woman who has an abortion should receive Rho(D) immunoglobulin. Before the patient's release from the facility, aspirated tissue should be examined to verify that villi or fetal parts are present. If villi or fetal parts cannot be identified with certainty, the tissue specimen should be sent for further pathologic examination and the patient alerted to the possibility of an ectopic pregnancy. If the tissue suggests a molar pregnancy, the patient should be so informed and appropriate follow-up instituted. The patient should receive instruction in the use of family planning methods.

APPENDIX C

COMPARISON OF ASTC ACT LICENSING REQUIREMENTS WITH HOSPITAL LICENSING REQUIREMENTS

(Hospital and Ambulatory Care Facilities Regulation, 77 Ill. Adm. Code Chapter 1, subchapter b, Parts 205 and 250)

The following ASTC Act requirements track the language of, or are substantively identical to, the Hospital Licensing Act requirements:

ASTC Regs. § 205.	Hosp. Lic. Regs. § 250.	Description
1350(b)-(f)	2440(a)(1)-(5)	Structural specifications for administration department and public areas
1360(b) (1) & (2)	2440(i)(2)	250 sq. ft. procedure rooms with communications system connecting with surgical suite control station
1360(c)(2)	2440(i)(4)(c) & (j)(3)(B)	Recovery rooms - ASTC: 80 sq. ft. per bed 3' between beds 4' at end of beds - Hospital: 70 sq. ft. per bed 4' between beds 3' at end of beds

ASTC Regs. § 205.	Hosp. Lic. Regs. § 250.	Description
1370	2440(i)(5) (A), (C)-(H), (J), (K), (M)-(O), (Q), (S) & (j)(4) (A), (C)-(H), (J), (K), (M)-(O), (Q), (S)	Specifications for support services areas including requirement for control station to permit visual surveillance of all traffic which enter operating suite
1380(b)	2440(c)(1)	Specifications for laboratory suite
1400(c)	2450(b)	Drinking fountains, telephone booths, vending machines and portable equipment located so as not to reduce the corridor width below required minimum
1400(f)	2450(d)	3'-8" doors to rooms access for stretchers (procedure rooms, recovery)

ASTC Regs. § 205.	Hosp. Lic. Regs. § 250.	Description
1400(g)	2450(e)	Swing-type doors on all openings between corridors and rooms or spaces subject to occupancy, except elevators
1400(h)	2450(f)	Doors not to swing into corridors
1400(i)	2450(h)	Safety glass, wire glass or plastic glazing on doors, sidelights, borrowed lights, and windows within 18" of floor
1400(j)	2450(m)	Thresholds and expansion joint covers made flush with floor to facilitate use of wheelchairs and carts
1400(i)	2450(i)	Firedoors - NFPA Std. 80
1400(k)	2450(r)	Paper towels or air dryers and waste receptacles at handwashing fixtures
1400(n)	2450(u)(3)	8'-0" ceiling minimum

ASTC Regs. § 205.	Hosp. Lic. Regs. § 250.	Description
1400(n)(1)	2450(u)(1)	Ceiling 2'-6" above main boiler header and connecting pipe
1400(n)(2)	2450(u)(2)	Ceiling height to accommodate ceiling equipment
1400(n)(3)	2450(u)(3)	7'-8" corridor & minor room ceiling
1400(n)(4)	2450(u)(3)	Suspended tracks, rails and pipes not less than 6'-8" above floor
1400(w)	2460(h)	Smooth cleanable ceilings without crevices (no acoustical ceilings)
1400(u)	2460(f)	Washable wall finish
1400(v)	2460(g)	Floor and wall penetrations tightly sealed; joints of structural equipment tightly sealed

ASTC Regs. § 205.	Hosp. Lic. Regs. § 250.	Description
1510(a)	2480(a)(1)	Mechanical systems tested to assure conformance with - Hospital: the requirements of the hospital's plans and specifications - ASTC: the ASTC regulations
1510(b)	2480(a)(2)	Mechanical instructions to be obtained by owner
1520(a)	2480(b)(1)	Detailed requirements for thermal and acoustical insulations
1520(b)	2480(b)(2)	" "
1520(c)	2480(b)(3)	" "
1520(f)	2480(b)(5)	" "
1530(a)	2480(c)(2)	Boiler and hot water heater requirements
1530(b)	2480(c)(3)	Heating system valved to isolate various sections

ASTC Regs. § 205.	Hosp. Lic. Regs. § 250.	Description
1540(b)	2480(d)(2)(A)	Airhandling system installation: NFPA 90-A-1975/1976
1540(d)	2480(d)(2)(B)	Outdoor air intake specifications
1540(g)	2480(d)(2)(D)	Air delivery and exhaust outlet specifications for procedure rooms
1540(i)	2480(d)(2)(I)	Filter efficiencies in accordance with ASHREA Stds.
1540(k)	2480(d)(2)(J)	Airtight seal between filter frames and on duct work
1540(m)	2480(d)(2)(M)	Fire and smoke dampers in accordance with NFPA 90A
1540(n)	2480(d)(2)(M)	Smoke detector specifications to shut down fans
1540(o)	2480(d)(2)(T)	Ventilation specifications for anesthesia storage rooms
1540(p)	2480(d)(2)(U)	Boiler room temperature specifications

ASTC Regs. § 205.	Hosp. Lic. Regs. § 250.	Description
1540(q)	2480(d)(2)(V)	Insulation specifications for boiler and heater rooms
1620(a)	2490(b)(1)	Acid-resistant plumbing fixtures
1620(b)	2490(b)(2)	Water supply spouts - 5" from rim of fixtures
1620(c)	2490(b)(3)	Valve fixtures in facilities used by medical and nursing staff
1710(a)	2500(a)	Electrical system requirements
1720	2500(b)	Switchboard and power panel specifications
1730	2500(c)	Panelboards on same floor as circuits
1740(a)	2500(d)(1)	Lighted building, approaches to building and parking lots
1740(c)	2500(d)(3)	Lighting specifications in procedure rooms
1770(a)	2500(f)(2)	X-ray installations

REPLY

BRIEF

No. 88-790

Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1989

BERNARD J. TURNOCK, M.D., M.P.H. Director of the Illinois Department of Public Health, et al.,

Appellants,

v.

RICHARD M. RAGSDALE, M.D., et al.,

Appellees.

On Appeal From The United States Court Of Appeals For The Seventh Circuit

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TABLE OF CONTENTS

Page

TABLE OF CONTENTS i

TABLE OF AUTHORITIES ii

ARGUMENT 1

A.

THIS COURT HAS APPELLATE JURISDICTION TO REVIEW THE FINAL JUDGMENT OF THE COURT OF APPEALS 1

B.

THE LOWER COURT LACKED JURISDICTION TO HEAR THE CHALLENGE TO THE PROVISIONS WHICH WERE NOT ENFORCED 3

C.

THE CHALLENGED PROVISIONS DO NOT VIOLATE THE CONSITUTIONAL RIGHT TO PRIVACY 4

1. The Challenged Provisions Do Not Unduly Burden The Abortion Decision 8

   a. Physical Plant Requirements 9

   b. Physician/Patient Relationship 10

   c. Certificate of Need Requirement 11

2. The Abortion-Neutral Statutes And Regulations Should Be Upheld Under The Rational Basis Test 13

D.

THE COURT OF APPEALS ERRONEOUSLY REFUSED TO SEVER ANY PROVISIONS IT FOUND UNCONSTITUTIONAL 17

CONCLUSION 18

TABLE OF AUTHORITIES

Page

CASES

Bates v. City of Little Rock, 361 U.S. 516 (1959)..... 14

Birth Control Centers, Inc. v. Reizen, 743 F.2d 352 (6th Cir. 1984)..... 16

Bolger v. Youngs Drug Product Corp., 463 U.S. 60 (1983)..... 12

Cleburne v. Cleburne Living Center, Inc., 473 U.S. 432 (1985)..... 14

Connecticut v. Menillo, 423 U.S. 9 (1975)..... 8

Dandridge v. Williams, 397 U.S. 471 (1970)..... 16

Eisenstadt v. Baird, 405 U.S. 438 (1972)..... 12

Hedd Surgi-Center v. Turnock, 711 F. Supp. 439 (N.D. Ill. 1989), *appeal docketed*, No. 89-1977 (7th Cir. May 10, 1989)..... 15

Kassel v. Consolidated Freightways Corp., 450 U.S. 662 (1981)..... 14

Kramer v. Union Free School Dist., 395 U.S. 621 (1969)..... 14

McDonald v. Bd. of Election Comm'rs of Chicago, 394 U.S. 802 (1969)..... 14

McGowan v. Maryland, 366 U.S. 420 (1961)..... 15

Palmer v. Thompson, 403 U.S. 217 (1971)..... 17

Planned Parenthood Ass'n v. Ashcroft, 462 U.S. 476 (1983)..... 8

Planned Parenthood v. Danforth, 428 U.S. 52 (1976)..... 11

Shapiro v. Thompson, 394 U.S. 618 (1969)..... 14

TABLE OF AUTHORITIES – Continued

Page

Sherbert v. Verner, 374 U.S. 398 (1963)..... 14

Tony and Susan Alamo Foundation v. Secretary of Labor, 471 U.S. 290 (1985)..... 14

United States v. Lee, 455 U.S. 252 (1982)..... 14

Wisconsin v. Yoder, 406 U.S. 205 (1972)..... 12

CONSTITUTIONAL PROVISIONS

U.S. CONST. Amend. XI..... 3

STATUTES

28 U.S.C. Section 1254(2).....1, 3

Ambulatory Surgical Treatment Center Act, Ill. Rev. Stat. ch. 111 ½, pars. 157-8.1 *et seq*..... *passim*

Health Facilities Planning Act, Ill. Rev. Stat. ch. 111 ½, par. 1151 *et seq*..... *passim*

Medical Practice Act, Ill. Rev. Stat. ch. 111, par. 4400-22..... *passim*

Ill. Rev. Stat. ch. 111, par. 4400-38..... 6

REGULATIONS

Ambulatory Surgical Treatment Center Licensing Requirements, 77 Ill. Adm. Code, Ch. 1, Section 205, Subchapter b ..... *passim*

ARGUMENT

A.

THIS COURT HAS APPELLATE JURISDICTION TO REVIEW THE FINAL JUDGMENT OF THE COURT OF APPEALS

In the opening brief, defendants demonstrated that this Court has appellate jurisdiction to review the final judgment entered by the Court of Appeals. That judgment held unconstitutional the challenged provisions of the Illinois Medical Practice Act (MPA), the Illinois Ambulatory Surgical Treatment Center Act (ASTCA) and related regulations, and the Illinois Health Facilities Planning Act (HFPA), to the extent any person or facility offers or performs, or desires to offer or perform first and early second trimester abortions or abortion-related gynecological procedures.

The plaintiffs argue that this matter is not subject to review under 28 U.S.C. Section 1254(2). In so arguing, the plaintiffs incorrectly focus upon the district court preliminary injunction order, rather than the decision of the Court of Appeals. Defendants seek review by appeal of the final judgment of the Seventh Circuit. Contrary to plaintiffs' contention (Pls.' Br. 7, 25-26), the Court of Appeals did not merely affirm the preliminary injunction order. That court also struck down and held unconstitutional the challenged statutes and regulations in the abortion context. (Jur. App. 24-25).[1]

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[1] The Joint Appendix is referred to as J.A. The Appendix to the Jurisdictional Statement is referred to as Jur. App. The trial transcripts are referred to as R.

In a belated attempt to bolster their argument, the plaintiffs now indicate an intention to submit proof on an equal protection challenge. (Pls.' Br. 6 fn. 4). This argument is contrary to the representations plaintiffs made to the district court after certification of the classes and issuance of the district court opinion. At that time, the plaintiffs clearly stated that given the scope of the proceedings and the court's order, they believed that there was no need for further trial proceedings. (J.A. 68-70).

Previously, plaintiffs acknowledged the Court of Appeals' holding that the ASTC "licensing provision . . . was itself unconstitutional as it applied to plaintiffs." (Pls.' Motion to Dismiss or Affirm 21). In their brief on the merits, however, plaintiffs inexplicably claim that this holding was not made. (Pls.' Br. 47).

The majority first found that the ASTC licensure requirement was unconstitutional in the abortion context. (Jur. App. 24). Next, the majority held that "once the licensing requirement falls, the remainder of the requirements fall with it . . . " (Jur. App. 25). In the alternative, the majority analyzed other statutory and regulatory provisions and concluded that they were constitutionally defective. (Jur. App. 25-32).

Thereafter, the majority rejected defendants' arguments on the issue of severability. (Jur. App. 32-33). Clearly, severance issues need not have been considered unless the majority struck down the challenged provisions. Thus, the Seventh Circuit judgment is final and this

Court has appellate jurisdiction under 28 U.S.C. Section 1254(2).[2]

B.

THE LOWER COURT LACKED JURISDICTION TO HEAR THE CHALLENGE TO THE PROVISIONS WHICH WERE NOT ENFORCED

In their opening brief, defendants demonstrated that the Seventh Circuit's assumption of jurisdiction over unenforced provisions conflicts with decisions of this Court and Courts of Appeal regarding justiciability standards as well as with decisions addressing the jurisdictional bar created by the Eleventh Amendment. The plaintiffs, however, attempt to posit the case as one involving mootness issues and claim that "a live federal controversy undoubtedly remains." (Pls.' Br. 34 fn. 23).

The uncontradicted evidence of record established that due to various court decisions, well prior to the commencement of this action, the State ceased to enforce certain challenged provisions: the abortion-specific language of par. 157-8.3 of the ASTC Act (Jur. App. 149-50); Sections 205.740 (Jur. App. 222) (prohibition of second trimester abortions in ASTCs) and 205.760 (Jur. App. 223) (abortion-specific reporting requirement) of the ASTC Regulations; and par. 4400-22 of the MPA. (Jur. App. 193).

---

[2] Assuming, *arguendo*, that appellate jurisdiction is lacking, this Court should review this matter by a grant of certiorari because of the important and substantial questions raised in this case.

Plaintiffs' reliance on certain "fact findings" in the majority opinion is misplaced. (Pls.' Br. 33 fn. 23). The unenforced provisions have neither been applied nor threatened to be applied to plaintiffs' activities. Thus, plaintiffs lack standing to challenge those statutes and regulations.

In addition, plaintiffs fail to specify what future conduct defendant State officials must change regarding the unenforced provisions to conform to the dictates of federal law. Even the Seventh Circuit noted that State officials cannot be required to remove or amend regulations which are not being enforced. (Jur. App. 13). Absent some ongoing violation of federal law, the jurisdictional barrier created by the Eleventh Amendment defeats plaintiffs' challenge to the unenforced statutes and regulations.

C.

THE CHALLENGED PROVISIONS DO NOT VIOLATE THE CONSTITUTIONAL RIGHT TO PRIVACY

In their opening brief, defendants demonstrated that the challenged statutes and regulations, as enforced, do not unduly burden the timing or availability of abortions and that the abortion-neutral provisions should be upheld as rationally related to legitimate and substantial state interests. Defendants argued that this appeal turns on whether the State of Illinois is authorized to license and regulate outpatient surgical facilities in which first and early second trimester abortions are performed to the same extent it licenses and regulates all other outpatient surgical facilities.

Plaintiffs' response fails to confront this threshold question directly. Instead, they rely on the findings of the district court which focused upon burdens purportedly caused by the challenged statutes and regulations as drafted. In so doing, plaintiffs ignore the State's enforcement policy decisions in order to exaggerate the impact of defendants' conduct on the constitutional right to privacy. Further, plaintiffs disregard the record in this case which established that the challenged standards for construction, maintenance, and operation of outpatient surgical facilities are constitutional as applied to those facilities in which abortions are performed.

In defending the Court of Appeals' decision striking the licensure requirement and the regulations as applied to outpatient surgical facilities which perform abortions, plaintiffs also argue that the Department of Professional Regulation's ability to discipline licensed physicians under the MPA is sufficient to protect the health and safety of women who choose to have abortions in such facilities. (Pls.' Br. 6-7).[3] The MPA provides, in pertinent part:

. . .

[3] The plaintiffs' citation to this statutory provision at p. 7 of their brief is inaccurate. There is an administrative rule (Section 1285.270), also incorrectly cited by plaintiffs, which further details the inspection requirements: i.e. the request for an order must be in writing, be signed by the Medical Coordinator, state one or more grounds for discipline alleged to be violated, identify the premises to be entered, and include an affidavit of a person having knowledge of facts upon which the request is based.

> The Disciplinary Board, upon a determination that *probable cause* exists that a violation of one or more of the grounds for discipline listed in Section 22 has occurred or is occurring on the business premises of a physician licensed under this Act, may issue an order authorizing an appropriately qualified investigator employed by the Department to enter upon the business premises with due consideration for patient care of the subject of the investigation so as to inspect the physical premises and equipment and furnishings therein. No such order shall include the right of inspection of business, medical, or personnel records located on the premises. . . .(emphasis added).

Ill. Rev. Stat. (1987), ch. 111, par. 4400-38.

It is the defendants' contention that there is a need to regulate *all* outpatient surgical facilities and a need to delineate certain standards of care in such facilities. (J.A. 165). It is plaintiffs' position that the State's regulatory authority is limited to the ability to discipline licensed physicians and the ability to inspect after it is shown that there is probable cause to believe that there has in fact been a violation of the MPA. (Pls.' Br. 6-7).

The plaintiffs have argued that there is no need for the State to license abortion facilities (J.A. 197), and that the mere "presence" of regulations produces a "chilling effect on the provision of abortion services." (J.A. 213-14). In the same vein, the plaintiffs imply that the Constitution requires a regulatory straitjacket be placed upon the State in this context. According to plaintiffs, when it comes to early abortions, it is "hands off to state regulation." (R. 834).

The extreme limitations which plaintiffs propose to place upon the State are wholly inappropriate. Such prohibitions undermine the State's duty and authority to minimize the risk of harm and injury to patients in ambulatory surgi-centers. The inappropriateness of the proffered restrictions is exemplified by the reactive nature of the State's regulatory authority under the MPA. Under that statute, after the patient has sustained some injury, the State can react and impose discipline upon licensed physicians. (R. 461). The State's position is that it has an interest in protecting patients who choose to utilize outpatient surgical facilities *before* an injury occurs.

The State's position is not unique. It is supported by the plaintiffs' *amici*, the National Abortion Federation (NAF) and Planned Parenthood Federation of America, Inc. (PPFA). According to these organizations, NAF-member and PPFA-affiliate facilities "must adhere to the standards of their respective organizations that address the quality and safety of the services provided." (Brief of NAF and PPFA at 6). The NAF and PPFA standards contain detailed requirements dealing with counseling and informed consent, qualifications of counselors, nursing care, training and supervision, preoperative care, operative care, after care, tissue disposal, equipment and physical plant, medical personnel, advertising standards, referral standards, and reporting standards. (Brief of NAF and PPFA at 1a-73a).

In many respects the NAF and PPFA standards are similar to the ASTC regulations struck down by the Seventh Circuit. In some cases the NAF and PPFA standards are more stringent. For example, the PPFA standards are very specific as to the type of surgical procedure which

may be utilized, the anesthesia which is recommended, and the examination of the fetal specimens which must occur. (*Id.* at 37a-39a). The PPFA standards also provide that contraception *must* be discussed with the patient, and that counselors *must* have knowledge regarding the necessary procedures for adoption and the location of adoption agencies. (*Id.* at 40a, 51a). Like the defendants, the NAF and PPFA recognize the need for standards that are designed to minimize the risk of harm and injury to the woman and to ensure a safe procedure.

1. The Challenged Provisions Do Not Unduly Burden The Abortion Decision

In their opening brief, defendants demonstrated that the majority erred in determining that the challenged provisions unduly burden the right to seek an abortion. Plaintiffs' response concedes that states can permissibly regulate abortion so long as no undue burden is created. (Pls.' Br. 31). That response, however, resurrects plaintiffs' unsupportable "medical necessity" test as an appropriate standard of review. (Pls.' Br. 32). Neither of the cases cited by plaintiffs, *Connecticut v. Menillo*, 423 U.S. 9 (1975) and *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476 (1983), supports such a proposition.

To the contrary, this Court found that a required pathology exam was "reasonably related to generally accepted medical standards" and furthers important health-related concerns. *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. at 487. In contrast, the lower court in this case struck down State regulations which were consistent with generally accepted medical standards, but which the

court held failed to meet the "medical necessity" test. (Jur. App. 137-38). Thus, the "medical necessity" test should be specifically rejected.

Plaintiffs' response emphasizes three allegedly burdensome requirements: a) the physical plant regulations; b) regulations which purportedly interfere with the physician-patient relationship; and c) the certificate of need requirement. (Pls.' Br. 5).[4]

a. Physical Plant Requirements

Plaintiffs inaccurately state that defendants characterize the physical plant regulations as standard for abortion facilities. (Pls.' Br. 12). Some of these regulations are standard throughout the construction industry. They are reasonably drafted to accommodate the range of outpatient surgical procedures which are performed in ASTCs. Plaintiffs acknowledge the reasonableness of such drafting: "ACOG recommends that freestanding and hospital-based ambulatory facilities meet hospital-like standards, because it is anticipated that procedures much more complicated than early abortions will be performed there." (Pls.' Br. 10).

The plaintiffs misconstrue the nature of the State's interests in establishing these regulations. Defendants are

---

[4] Plaintiffs baldly claim that many of these standards "actually harm the woman's health." (Pls.' Br. 5). They cite no evidence that performance of abortions in ASTCs is actually harmful to the patient. Plaintiffs do not claim that Dr. Ragsdale harmed the 40,000 patients who had abortions in his facility while licensed for 12 years as an ASTC.

not solely interested in the safety of early abortions. (Pls.' Br. 39). Rather, the State's interests cover all outpatient surgical procedures performed in ASTCs. The challenged regulations reflect those interests.

Plaintiffs attempt to mislead the Court regarding the costs associated with the physical plant requirements. (Pls.' Br. 17). Contrary to plaintiffs' statement, the cost estimates testified to by Dr. Ragsdale's landlord were not solely directed to bringing his facility into compliance with the regulations. Rather, the estimates encompassed expenses for bringing the "entire building . . . into compliance with certain of the codes." (J.A. 324). Further, these cost estimates had no impact on the landlord's decision not to renew Dr. Ragsdale's lease. (J.A. 321). Thus, the record in this case does not support plaintiffs' exaggerated cost claims.[5]

b. Physician/Patient Relationship

Plaintiffs assert that two abortion-specific regulations interfere with the physician/patient relationship. First, they claim that the State should not require counseling to include a discussion of alternatives. Plaintiffs' position not only contradicts their expert witness, but also many of their *amici*.

---

[5] Another misstatement of fact relates to plaintiffs' claim that the ventilation system can cost several hundred thousand dollars to install and operate. (Pls.' Br. 15). Dr. Ragsdale's own cost estimates indicate that an extra $15,000.00 might be needed for the heating, ventilation and air conditioning requirements. (J.A. 35, Pls.' Ex. 18).

Dr. Hern testified that he always includes in his counseling a discussion of the alternatives for dealing with the pregnancy. (J.A. 210). This testimony is consistent with the position advocated by the American College of Obstetricians and Gynecologists (J.A. 55; Brief of ACOG *et al.* at 29), the National Abortion Federation (Brief of NAF *et al.* Appendix 7a-8a) and Planned Parenthood Federation of America, Inc. (Brief of NAF *et al.* Appendix 49a-50a). Because this requirement is designed to ensure the patient's informed consent, it should be upheld. *Planned Parenthood v. Danforth*, 428 U.S. 52, 66-67 (1976).

Second, plaintiffs misread ASTC regulation Section 205.730(b)(2) (D) (Jur. App. 221) to preclude the physician performing the abortion from providing the counseling. (Pls.' Br. 20). The regulation, however, is directed at non-physician counselors and is intended to preclude arrangements which compensate those counselors only if the patient has an abortion. As such, there is no interference with the physician/patient relationship.

c. Certificate of Need Requirement

Plaintiffs' claim that the certificate of need requirement causes a significant decrease in access to abortion services (Pls.' Br. 20) is unsupported by this record. There is no evidence that any abortion provider desiring to operate an ASTC was ever denied a certificate of need. In fact, Dr. Ragsdale's proposal for relocating his facility was approved. (J.A. 130-31). Thus, plaintiffs have failed

to demonstrate that the certificate of need requirement unduly burdens the abortion decision.[6]

Similarly, plaintiffs' assertions that the challenged provisions "impose an enormous burden" (Pls.' Br. 27), limit access, cause unnecessary travel, dramatically increase cost (Pls.' Br. 19), erect "nearly insurmountable obstacles" (Pls.' Br. 24), and effectively "prohibit abortion in many parts of the state" (Pls.' Br. 36) are also unfounded. These assertions ignore the fact that defendants have not limited abortion services to ASTC facilities. Pregnancy terminations can be and are performed in doctors' offices, clinics, outpatient surgical facilities, and hospitals.[7]

Plaintiffs also overlook the fact that the cost of services at Dr. Ragsdale's facility while licensed as an ASTC was only a fraction of what is charged in a hospital. Dr. Ragsdale charged $250.00 per patient (Jur. App. 143)

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[6] The opposition to Dr. Ragsdale's facility voiced at the public hearing (Pls.' Br. 20-21) did not affect the determination that the certificate of need requirements were met. As noted by Judge Coffey in his dissent from the majority opinion in this case, moreover, it "stretches the imagination that . . . the exercise of one's First Amendment rights to object to an issue be treated somehow as creating a burden on a woman's right to an abortion." (Jur. App. 70).

[7] The availability of alternatives distinguishes this case from the cases relied upon by plaintiffs where absolute prohibitions affecting fundamental rights were successfully challenged. *See e.g., Bolger v. Youngs Drug Product Corp.*, 463 U.S. 60 (1983) (ban on mailing of unsolicited advertisements for contraceptives); *Wisconsin v. Yoder*, 406 U.S. 205 (1972) (compulsory school attendance law); and *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (prohibition on contraception).

while a hospital may charge $1000.00 per abortion. (Pls.' Br. 18). Further, Dr. Ragsdale testified only to a *de minimis* cost increase relating to compliance with the challenged provisions in his new facility.[8]

Similarly, plaintiffs disregard the fact that at the time of trial 22 of the 42 licensed ASTCs provided abortion services (J.A. 241), that Dr. Ragsdale performed over 42,000 abortions as an ASTC licensee for 12 years (R. 43), and that more than 65,000 abortions are performed in Illinois annually. (Jur. App. 121).

These facts and figures refute plaintiffs' contention that defendants have deprived them of their constitutional right to privacy. To the contrary, defendants have taken steps to ensure that the abortion decision remains with the patient and her physician and to protect the health and safety of women who choose to have abortions in ASTCs.

2. The Abortion-Neutral Statutes And Regulations Should Be Upheld Under The Rational Basis Test

In their opening brief, defendants established that the abortion-neutral statutes and regulations are rationally related to legitimate and substantial state interests. Plaintiffs counter with cases which reject such a standard

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[8] Plaintiffs' claim that there was a threatened closure of Dr. Ragsdale's facility (Pls.' Br. 4-5) is contradicted by his own testimony. All of the estimated cost increases associated with the relocation of his practice were to be absorbed or covered by increasing fees. (J.A. 144, 146). Closure was never "imminent." (Pls.' Br. 6).

of review where fundamental rights have been impacted.[9] (Pls.' Br. 45). That analysis is inappropriate here, because no undue burden has been shown.[10] (Defs.' Br. 40-45).

Similarly, the cases relied upon by plaintiffs in which a state's safety interest was deemed illusory (Pls.' Br. 42-43, 46) are inapposite.[11] Here, the possibility that medical complications will occur exists in the abortion context as well as with other outpatient surgical procedures. Further, requiring outpatient surgical centers to comply with accepted medical, safety, building, and sanitation requirements is a permissible exercise of state police power.

Plaintiffs also claim that defendants have an evidentiary burden in this context (Pls.' Br. 45) and that this

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[9] *See e.g., Kramer v. Union Free School Dist.*, 395 U.S. 621 (1969) (right to vote); *Shapiro v. Thompson*, 394 U.S. 618 (1969) (right to travel); *Sherbert v. Verner*, 374 U.S. 398 (1963) (free exercise of religion); and *Bates v. City of Little Rock*, 361 U.S. 516 (1959) (freedom of association).

[10] *Tony and Susan Alamo Foundation v. Secretary of Labor*, 471 U.S. 290, 304-05 (1985) (minimum wage, overtime and recordkeeping standards permissibly applied to workers engaged in commercial activities of a religious foundation); *United States v. Lee*, 455 U.S. 252, 260 (1982) (rejecting claim that taxes were spent in a manner which violates religious belief); and *McDonald v. Bd. of Election Comm'rs of Chicago*, 394 U.S. 802, 807 (1969) (failure to extend absentee ballot procedures to inmates does not violate voting rights).

[11] *See e.g., Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 448 (1985) (no special threat posed by group home for mentally retarded); *Kassel v. Consolidated Freightways Corp.*, 450 U.S. 662, 671 (1981) (no special safety interest in prohibiting use of certain large trucks on State highways).

burden has not been met. (Pls.' Br. 21). First, under the rational basis analysis, the State's burden is not evidentiary. "A statutory discrimination will not be set aside if any state of facts reasonably may be conceived to justify it." *McGowan v. Maryland*, 366 U.S. 420, 426 (1961). Second, defendants proved not only a rational basis for the challenged provisions, but also a compelling basis for protecting the public health and safety. (See Defs.' Br. 14-21, 40-43).[12]

The ASTC Act and related regulations are rationally related to the State's interest in ensuring that surgical procedures are performed at these facilities under circumstances enhancing the public health and safety of patients. The HFP Act is rationally related to the State's interest in establishing a comprehensive and less costly, but safe, health care system. Because these laws are reasonably related to legitimate government objectives, they should be sustained.

Plaintiffs claim that the defendants are irrationally attempting to regulate experienced physicians to the exclusion of the occasional abortion provider. (Pls.' Br. 43). Further, they assert that there is no evidentiary basis for this exemption. (Pls.' Br. 22).

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[12] The district court has acknowledged, moreover, that the portion of its opinion stating that defendants had failed to demonstrate a rational basis for the statutes and regulations is dictum. *Hedd Surgi-Center v. Turnock*, 711 F. Supp. 439, 444 n.8 (N.D. Ill. 1989), *appeal docketed*, No. 89-1977 (7th Cir. May 10, 1989). The district court has also stated that it is "unlikely" that the challenged statutes would not survive a rational-relationship challenge. 711 F. Supp. at 444.

The assumption that physicians who perform abortions in licensed ASTCs are more experienced and more responsible is one which the plaintiffs make without evidentiary support. Plaintiffs emphasize that the skill, experience, and professional integrity of the physician are important factors affecting the safety of the abortion procedure. (Pls.' Br. 9). Other factors affecting the woman's health and safety include the duration of the pregnancy, existence of sterile conditions, the availability of emergency facilities, the abortion technique, and the type of anesthesia. (Defs.' Br. 11-13). Further, plaintiffs' expert witness testified that if a lay-operated facility has no medical director, the responsibility and liability for medical decisions may rest with individuals with no understanding or professional experience with those responsibilities. (J.A. 221). *Accord, Birth Control Centers, Inc. v. Reizen*, 743 F.2d 352 (6th Cir. 1984) (In outpatient surgical facilities non-physicians may have control over personnel, equipment and design of the facility. Therefore, it was not unreasonable for the State to decide to regulate free-standing surgical facilities including abortion clinics, while not regulating physicians' offices).

The statutes and regulations which were invalidated in this case reflect a reasonable decision by the State of Illinois. The State can rationally utilize its limited resources to regulate those facilities which have made it their business to perform surgical procedures, and are thus more in need of scrutiny as to appropriate staff, equipment and record keeping. States are not required by the Constitution to "choose between attacking every aspect of a problem or not attacking the problem at all." *Dandridge v. Williams*, 397 U.S. 471, 486-87 (1970).

D.

THE COURT OF APPEALS ERRONEOUSLY REFUSED TO SEVER ANY PROVISIONS IT FOUND UNCONSTITUTIONAL

In their opening brief, defendants demonstrated that the majority erred in rejecting the argument that any purportedly unconstitutional provisions be severed. Plaintiffs assert that the majority properly refused to rewrite the challenged provisions. (Pls.' Br. 48).

Defendants ask this Court to review these statutes and regulations independently and on their own merit. In their response, plaintiffs had no difficulty focusing their attention on the three provisions they claim to be most burdensome. (Pls.' Br. 5, 48). That is precisely the type of analysis which is required.

The plaintiffs also suggest that the challenged legislation is unconstitutional because of alleged improper motives of the General Assembly. (Pls.' Br. 2-3). This suggestion is simply not supported by the legislative history, which demonstrates that while both sides of the abortion issue were debated, the purpose of the legislation was to provide cost-effective, safe, non-hospital settings for outpatient surgical procedures. (See Brief of Certain Illinois Senators and Representatives as *Amici Curiae* in Support of Appellants). In addition, the alleged illicit motivations of legislators has never been considered an adequate ground for finding a statute unconstitutional. *Palmer v. Thompson*, 403 U.S. 217, 224-26 (1971).

CONCLUSION

For these reasons, this Court should find that it has jurisdiction over this appeal, reverse the judgment of the Court of Appeals for the Seventh Circuit and vacate the injunction entered against the defendants.

Respectfully submitted,

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November 13, 1989

MOTION

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No. 88-790

In The

Supreme Court of the United States

October Term, 1988

BERNARD J. TURNOCK,
et. al.

Appellants,

vs.

RICHARD M. RAGSDALE, M.D.,
et. al.

Appellees.

On Appeal From The United States Court Of Appeals, Seventh Circuit

MOTION FOR LEAVE TO FILE A BRIEF AMICUS CURIAE OF AMERICAN FAMILY ASSOCIATION AND LEGAL ACTION FOR WOMEN IN SUPPORT OF APPELLANTS

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TABLE OF CONTENTS

Page

MOTION FOR LEAVE TO FILE A BRIEF AMICUS CURIAE IN SUPPORT OF THE STATE OF ILLINOIS 1

TABLE OF AUTHORITIES 7

LAW AND ARGUMENT 9

I. ILLINOIS MAY CONSTITUTIONALLY REGULATE AND LICENSE OUT PATIENT SURGICAL FACILITIES WHICH PERFORM ABORTIONS TO THE SAME EXTENT IT REGULATES OUT PATIENT FACILITIES THAT DO NOT PERFORM ABORTIONS 9

CONCLUSION 21

CERTIFICATE OF SERVICE 22

MOTION FOR LEAVE TO FILE A BRIEF AMICUS CURIAE IN SUPPORT OF THE STATE OF ILLINOIS

American Family Association, Inc. (AFA) and Legal Action for Women (LAW), Moving Parties herein, respectfully move this Honorable Court for an order granting leave to file the attached Brief Amicus Curiae. AFA has requested permission from Appellant by its attorney, Mr. Neil F. Hartigan, Esq., and from Appellee, by its Attorneys, Ms. Colleen K. Connell, Esq., and Mr. Alan S. Gilbert.

The attached Brief supports the position of the Appellant in this case. The issue before this Court concerning the Constitutionality of the abortion facility regulations will significantly affect the position of Amicus as it seeks to protect women from the physical harms associated with the abortion process.

INTEREST OF AMICUS CURIAE

American Family Association's Interest

The American Family Association, Inc., is a non-profit organization incorporated in 1977 under its original name of National Federation for Decency, Inc. (NFD). AFA continues to operate as a leader of citizen and church participation to promote traditional American values and apply the Biblical ethic in society. As Amicus, American Family Association, Inc., has members in all 50 states; over 520 chapters of local citizens who are active in offering individuals alternatives to abortions; and over 360,000 subscribers to its monthly newsletter, AFA Journal. Amicus also provides counseling and referral services to pregnant women who seek

alternatives to abortion.

The ability of a state to protect the welfare of all its citizens, including the unborn, is vital to the efforts of the American Family Association membership. American Family Association, Inc., seeks to promote a healthful family environment for all Americans and it recognizes the need to afford the unborn such an opportunity. The position of the American Family Association, Inc., will support the interest of the State of Illinois to protect the lives of the unborn and to use tax revenues in a manner which will support the interest of citizens within the state.

Serious efforts have been under way to protect women form physical harm caused by unregulated abortion procedures. In the interest of continuing to inform citizens regarding

their ability to protect themselves from such harms this action is most important to the inquiry. The parties have written comprehensive arguments and AFA will not repeat them. Rather, AFA will highlight certain concepts it wishes the Court to consider.

The ability of AFA to call for such protections for women has been fundamentally affected by the court's ruling. Amicus and the citizens they represent would be severely harmed by affirming the Seventh Circuit finding with respect to the Constitutionality of the statute regulating abortion facilities.

Legal Action For Women's Interest

Legal Action For Women (LAW) is an organization formed to counsel and assist

women who have been physically or emotionally harmed by abortion practices. LAW is headquartered in Pensacola, Florida, but counsels women across the nation. LAW also provides women who have been injured with names of attorneys in their area who may be able to assist them in a legal action against the negligent abortion provider.

Through its telephone counseling service LAW has encountered numerous women who have been permanently disabled by negligent abortion providers. The counselors have spoken with families of young women who have died as a result of a negligently performed abortion.

LAW has called for women to seek legal recourse against those who have caused them injury. It also seeks to require abortion providers to act in a responsible and medically sound manner and supports state regulations which

minimize the risks to women seeking an abortion.

Therefore, AFA and LAW respectfully request this Honorable Court to grant leave to file the attached Brief Amicus Curiae in this important case and to reverse the decisions of the court below.

Respectfully submitted,

Peggy M. Coleman
Attorney for
AFA and LAW

TABLE OF AUTHORITIES

Page

Cases

City of Akron v Akron Center for Reproductive Health, 462 U.S. 416 (1983) . . . . . .

Planned Parenthood Association of Kansas City v Ashcroft, 462 U.S. 476 (1983) . . . . . .

Ragsdale v Turnock, 625 F.Supp. 1212 (N.D. Ill. 1985) . . . . . .

Ragsdale v Turnock, 841 F.2d 1358 (7th Cir. 1988) . . . . . .

Reproductive Health Services v Webster, 851 F.2d 1071 (8th Cir. 1988) . . . . . .

Roe v Wade, 410 U.S. 416 (1983) .

Webster v Reproductive Health Services, _____ U.S. _____, 57 U.S.L.W. 5023 (1989) . . . .

Statutes

Ill. Rev. Stat. §205.1310-1390

Ill. Rev. Stat. §205.1540

Ill. Rev. Stat. §205.120

Ill. Rev. Stat. §205.320-40

Ill. Rev. Stat. §205.410

Ill. Rev. Stat. §205.350

Ill. Rev. Stat. §205.420

Ill. Rev. Stat. §205.510

Ill. Rev. Stat. §205.520

Ill. Rev. Stat. §205.540

Ill. Rev. Stat. §205.730(a)

Ill. Rev. Stat. §205.730(b)

Ill. Rev. Stat. §205.740

LAW AND ARGUMENT

I. ILLINOIS CAN CONSTITUTIONALLY REGULATE AND LICENSE OUTPATIENT SURGICAL FACILITIES WHICH PERFORM ABORTIONS TO THE SAME EXTENT IT REGULATES OUTPATIENT FACILITIES THAT DO NOT PERFORM ABORTIONS.

This case was brought by abortion providers in Illinois under the guise of protecting the health of pregnant women seeking an abortion. Admittedly, the regulations would require alterations in the physical structure of the abortion clinic and a change in the current system of abortion counseling. The abortion providers would have this Court declare that the United States Constitution requires a special exemption for them in the practice of abortion surgery. To do so, however, would be to leave the abortion industry virtually unregulated.

The Seventh Circuit found that the

Illinois regulation of Ambulatory Surgical Treatment Centers (ASTC) unduly burdened a woman's ability to procure an abortion. Ragsdale v Turnock, 841 F.2d 1358 (7th Cir. 1988). The Court relied on the limitations abortion regulation as set forth in City of Akron v Akron Center for Reproductive Health, 462 U.S. 416 (1983). In addition, the court based its analysis on the rigid trimester approach set forth in Roe v Wade, 410 U.S. 113 (1973). As this Court noted in Webster v Reproductive Health Services, ____ U.S. ____, 57 U.S.L.W. 5023 (1989). The trimester approach set forth in Roe is unworkable in principle and practice. This approach "is hardly consistent with the notion of a Constitution cast in general terms, as ours is, and usually speaking in general principles, as ours does. The key elements of the Roe framework - trimester and viability - are

not found in the text of the Constitution or in any place else one would expect to find a Constitutional principle. Since the bounds of the inquiry are essentially indeterminate, the result has been a web of legal rules that have become increasingly intricate, resembling a code of regulations rather than a body of Constitutional doctrine." 57 U.S.L.W. at 5030.

In Webster this Court also discussed regulations concerning the need to perform certain viability tests. The Court stated:

> To the extent that the viability tests increase the cost of what are in fact second-trimester abortions, their validity may also be questioned under Akron, 462 U.S., at 434-435, where the Court held that a requirement that second trimester abortions must be performed in hospitals was invalid because it substantially increased the expense of those procedures.
>
> We think that the doubt cast upon the Missouri statute

by these cases is not so much a flaw in the statute as it is a reflection of the fact that the rigid trimester analysis of the cause of a pregnancy enunciated in Roe has resulted in subsequent cases like Colautti and Akron making constitutional law in this area a virtual Procrastean bed. Statutes specifying elements of informed consent to be provided abortion patients, for example were invalidated if they were thought to "structur[e] ... the dialogue between the woman and her physician." Thornburgh v American College of Obstetricians and Gynecologist, 476 U.S. 747.763 (1986). As the dissenters in Thornburgh pointed out, such a statute would have been sustained under any traditional standard of judicial review, id., at 802(White, J., dissenting), or for any other surgical procedure except abortion. Id., at 783 (Burger, C.]., dissenting).

57 U.S.L.W. at 5030.

The Court in Webster went on to discuss pre-viability regulations and concluded that "we do not see why the State's interest in protecting potential human life should come into existence only at the point of viability, and that

there should therefore, be a rigid line allowing state regulation after viability by prohibiting it before viability." Id.

As a reflection of this Court's observations in Webster regarding the regulatory nature of abortion decisions, the Seventh Circuit struck the facility requirements as being overly burdensome. In doing so, the court engaged in two separate analyses: whether the regulation were medically necessary, 841 F.2d at 1368; and whether the increased cost resulting from the regulations is unduly burdensome, 841 F.2d at 1370.

The regulations enacted by the Illinois legislature are designed primarily to protect the health of women seeking an abortion performed in an ASTC. The abortion providers would have this Court believe that the abortion procedure is virtually risk free and that the safeguard the State wishes to implement

only increases the potential risk.

The privacy interests recognized by this Court in Roe are not furthered by the lack of medically sound regulations for abortion surgery. One of the primary arguments this Court heard in Roe is that the ability of a woman to obtain a legal abortion will reduce health risks associated to the practices of illegal abortions. The Court specifically noted:

> The State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. This obviously extends at least to the performing physicians and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise. The prevalence of high mortality rates a illegal "abortion mills" strengthens, rather than weakens, the State's interests in regulating the condition and which abortions are performed. Moreover, the risk to the woman increases as her pregnancy

continues. Thus, the State retains a definite interest in protecting the woman's own health and safety when an abortion is proposed at a late stage of pregnancy.

410 U.S. at 150.

The safety interests enumerated by this Court in Roe are precisely those the Illinois legislature addressed in its regulatory scheme. The regulation addresses the physical design of the ASTC, Ill. Rev. Stat. §§205.1310-1390, 205.1540; a disclosure of the identity of the owners and operators of the facility, §205.120; essential personnel and staff qualifications, §§205.320-40, 204.350; necessary equipment, §205.410; sanitation requirements, §205.420; emergency procedures, §205.510; anesthesia procedures and written consent to all procedures, §205.520; post-operative procedures, §205.540; diagnosis of pregnancy for those seeking an abortion, §205.730(a); counseling with respect to

risks and complications, §205.730(b); and prohibition against performing an abortion in which the unborn child is older than twelve weeks, §205.740.

The State's interest in the health of the pregnant woman is not diminished by the fact that she seeks an early term abortion. The interest in the woman's welfare is essentially the same whether she seeks an early term abortion or waits until after the point of viability.

The Seventh Circuit applied the standard of "medical necessity" to the facility and procedural regulation. This Court has never subscribed to the view that only regulations which were "medically necessary" to the abortion procedure were Constitutionally valid. This Court in Planned Parenthood Association of Kansas City v Ashcroft, 462 U.S. 476, 487 (1983) upheld the requirement that all tissue be submitted

to a pathologist since it is "reasonably related to generally accepted medical standards and 'further[s] important health-related state concerns.' City of Akron, ante, at 430."

There is no suggestion that the regulations contain requirements that are not "reasonably related to generally accepted medical standards." The criticism leveled against the regulations is that they make the facility "hospital-like" and may be "psychologically detrimental" to the patient. Ragsdale v Turnock, 625 F.Supp. 1212, 1230 n.23 (N.D. Ill. 1985). There is no Constitutional requirement that the State insure an abortion procedure that is free from psychological pressures. The interest of the State lies in the need to provide women seeking an abortion with safe procedures, performed by competent personnel in facilities

designed to minimize health risks.

The Seventh Circuit also found that the regulations increased the cost of the abortion to the point that it was unconstitutionally burdensome. In Webster, this Court recognized that the viability tests required by the State of Missouri would increase the cost of the abortion, but stated that "we are satisfied that the requirement of these tests permissibly furthers the State's interest in protecting potential human life." 57 U.S.L.W. at 5031, and found the provision to be Constitutional.

As noted earlier, the interest of the State under the present regulation is to protect the health of the pregnant woman. The Court has not recognized that this interest increases as the term of the pregnancy progresses or that this interest is a part of any sliding scale. Consequently, the interest of the State

in protecting the health of the pregnant woman the term of the pregnancy.

The abortion providers alleged that compliance with the regulations would result in an increase of $25 to $40 for the cost of an abortion. 841 F.2d 1370. In Reproductive Health Services v Webster, 851 F.2d 1071, 1075 n.5 (8th Cir. 1988). The Court found that the viability tests would add $125 to $250 to the cost of an abortion. The Seventh Circuit found that when compared with the added cost of the regulations examined by this Court in Ashcroft, the Illinois regulatory scheme imposed a burdensome cost. When compared with this Court's latest pronouncement, however, the added cost is relatively minor. This is particularly true when compared in light of the different State interest involved. In Webster the State sought to protect the unborn life. In this case the State

seeks to protect the life and health of women who are vested with full and unquestionable Constitutional rights and privileges. To deny the State the ability to regulate abortion procedures is to jeopardize the health and well-being of thousands of women.

CONCLUSION

The Seventh Circuit erroneously found the regulations unconstitutional. This decision is inconsistent with the basic duty and obligation of the State to protect its citizens.

These regulations simply reflect an effort on the part of the State to minimize the risks involved in an abortion procedure. These regulations are consistent with other health-related statutes and conform with generally accepted medical practices.

For these reasons, in addition to those urged by Appellant herein, the decision below should be reversed.

Respectfully submitted,
American Family
Association, Inc.

Peggy M. Coleman
Legal Counsel
Attorney for Amicus Curiae

CERTIFICATE OF SERVICE

I hereby certify that three copies of the foregoing Brief Amicus Curiae of American Family Association, Inc. and Legal Action For Women have been mailed this third day of August, 1989, to the following counsel of record:

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MOTION

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No. 88-790, No. 88-805, No. 88-1125

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM 1989

No. 88-790

TURNOCK v. RAGSDALE

ON CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE EIGHTH CIRCUIT

No. 88-805

OHIO v. AKRON CENTER FOR
REPRODUCTIVE HEALTH

ON APPEAL TO THE UNITED STATES COURT OF
APPEALS FOR THE SIXTH CIRCUIT

No. 88-1125

HODGSON v. ILLINOIS

ON APPEAL TO THE UNITED STATES COURT OF
APPEALS FOR THE SEVENTH CIRCUIT

MOTION TO ALLOW COUNSEL TO REPRESENT CHILDREN UNBORN AND BORN ALIVE

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CONTENTS

Interest of Counsel.....1

Summary of Argument.....1

Argument.....2

THE UNBORN HAVE A CONSTITUTIONAL RIGHT TO BE ESPECIALLY REPRESENTED BY COUNSEL TO PROVE THEIR LIVES ARE PROTECTED BY THE U.S. CONSTITUTION...2

1.
THIS COURT EFFECTED AND MAINTAINS THE ROE v. WADE KILLINGS BY UNCONSTITUTIONALLY REFUSING TO ALLOW COUNSEL TO REPRESENT THE UNBORN AND DEFEND THEIR RIGHT TO LIFE UNDER THE U.S. CONSTITUTION.....2

2.
THIS COURT EFFECTED THE ROE v. WADE KILLINGS BY UNCONSTITUTIONALLY REFUSING TO ALLOW PRIOR NOTICE OF THE CONSTITUTIONAL STANDARDS, THE BURDENS, OR THE EVIDENCE WHICH IT USED TO INFER THAT THE LIVES OF THE UNBORN ARE NOT PROTECTED BY THE U.S. CONSTITUTION...5

3.
THIS COURT EFFECTED THE ROE v. WADE KILLINGS BY UNCONSTITUTIONALLY USING A SECRET EVIDENTIARY PROCESS TO FIND EVIDENCE TO INFER THAT THE LIVES OF THE UNBORN ARE NOT PROTECTED BY THE U.S. CONSTITUTION.....9

4.
THIS COURT EFFECTED AND MAINTAINS THE ROE v. WADE KILLINGS BY UNCONSTITUTIONALLY REFUSING TO ALLOW ITS EVIDENCE, WHICH IT USED TO INFER THAT THE LIVES OF THE UNBORN ARE NOT PROTECTED BY THE U.S. CONSTITUTION, TO BE CONFRONTED AND CROSS-EXAMINED....11

5.
THIS COURT EFFECTED AND MAINTAINS THE ROE v. WADE KILLINGS BY UNCONSTITUTIONALLY REFUSING TO ALLOW EVIDENCE TO BE PRESENTED ON BEHALF OF THE UNBORN TO ESTABLISH THEIR RIGHT TO LIFE UNDER THE U.S. CONSTITUTION.....13

Issues Raised by Counsel for the Unborn, Not Raised by the Parties.....17

Conclusion.....18

TABLE OF AUTHORITIES

Cases:

Dred Scott v. Sanford, 19 How. 393.....6

Goldberg v. Kelly, 397 U.S. 254.....4

Imbler v. Pachtman, 424 U.S. 409 5

In Re Gault, 387 U.S. 1.....4

United States v. Altstoetter, 3 Trials of War Criminals Before the Nuernberg Military Tribunals (1951).....5,16-17

Books:

4 Collected Works of Abraham Lincoln (Basler ed. 1953).....6

Briefs Filed In This Court:

Amicus Curiae Brief by the Legal Defense Fund for Unborn Children, filed in this case.....17

Petition for Rehearing, Doe v. Bolton, 410 U.S. 179 (1973).....2,8,10,12,15

U.S. Constitution:

Sixth Amendment-"Assistance of Counsel"...4

Fifth Amendment-"Due Process" 4

MOTION TO ALLOW COUNSEL TO REPRESENT CHILDREN UNBORN AND BORN ALIVE

The Court is moved to allow Alan Ernest to represent the victims being killed by Roe v. Wade, 410 U.S. 113, as counsel or guardian ad litem, for the purpose of defending their right to life under the U.S. Constitution.

INTEREST OF COUNSEL

Alan Ernest is a lawyer in the District of Columbia and a member of the bar of this Court. His purpose is to prove that the guarantee of life to "any person," made in the U.S. Constitution, does include the unborn.

This is effectively a motion to allow retained counsel since there will be no expense to this Court, or to the taxpayers.

SUMMARY OF ARGUMENT

The unborn have a constitutional right to be especially represented by counsel to prove that their lives are specifically guaranteed by the U.S. Constitution.

Argument

THE UNBORN HAVE A CONSTITUTIONAL RIGHT TO BE ESPECIALLY REPRESENTED BY COUNSEL TO PROVE THEIR LIVES ARE PROTECTED BY THE U.S. CONSTITUTION.

1.

THIS COURT EFFECTED AND MAINTAINED THE ROE v. WADE KILLINGS BY UNCONSTITUTIONALLY REFUSING TO ALLOW COUNSEL TO REPRESENT THE UNBORN AND DEFEND THEIR RIGHT TO LIFE UNDER THE U.S. CONSTITUTION.

Counsel did not especially represent the unborn in the U.S. District Court, or at any stage in Roe v. Wade. An original party objected that the unborn should be represented by counsel in this Court:

> (T)he Court should have every benefit of a complete record and the representation of a guardian ad litem for that fetal entity and for its natural right to develop to birth.[1]

But this Court refused to allow counsel to represent the unborn and defend their right to life under the U.S. Constitution. Thus the killings commenced.

And the Supreme Court has maintained the killings by steadfastly refusing to

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1. Petition for Rehearing 5, Doe v. Bolton, 410 U.S. 179 (1973), denied 410 U.S. 959 (1973).

allow counsel to represent the unborn, and defend their right to life under the U.S. Constitution.[2]

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2. The Court has refused to allow counsel for the unborn in all its abortion cases. Some are: Colautti v. Franklin, 439 U.S. 379, motion to allow counsel for the unborn denied 437 U.S. 902; Anders v. Floyd, 440 U.S. 445, motion to allow counsel for the unborn denied 439 U.S. 890; Bellotti v. Baird, 443 U.S. 622, motion to allow counsel for the unborn denied 439 U.S. 1065; Ashcroft v. Freiman, affirmed 440 U.S. 941, motion to allow counsel for the unborn denied, 440 U.S. 941; United States v. Zbaraz, 448 U.S. 358, motion to allow counsel for the unborn denied 444 U.S. 1030; Harris v. McRae, 448 U.S. 297, motion to allow counsel for the unborn denied 445 U.S. 941; H.L. v. Matheson, 450 U.S. 398, motion to allow counsel for the unborn denied 445 U.S. 959; Simopoulos v. Virginia, 462 U.S. 506, motion to allow counsel for the unborn denied 458 U.S. 1104; Planned Parenthood of Kansas City v. Ashcroft, 462 U.S. 476, motion to allow counsel for the unborn denied 458 U.S. 1104; Akron Center for Reproductive Health v. Akron, 462 U.S. 416, motion to allow counsel for the unborn denied 458 U.S. 1104; Diamond v. Charles, 90 L Ed 2d 48 (1986), motion to allow counsel for the unborn denied 87 L Ed 2d 704; Thornburgh v. American College of Obstetricians, 90 L Ed 2d 779 (1986), motion to allow counsel for the unborn denied 87 L Ed 2d 702; Hartigan v. Zbaraz, 98 L Ed 2d (1988), motion to allow counsel to for the unborn denied 93 L Ed 2d 697, and Webster v. Reproductive Health Services, ___ U.S. ___ (1989).

The unborn have a constitutional right to be represented by counsel in this case to defend their right to life under the U.S. Constitution.[3] Judges who willfully

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3. Even in civil proceedings, where crucial deprivations are threatened, such as loss of welfare, due process guarantees (1) prior notice of the factual and legal bases; (2) the right to be represented by counsel; (3) the right to confront and cross-examine adverse evidence; (4) the right to present evidence. Goldberg v. Kelly, 397 U.S. 254, 268-271 (1970). See also, In Re Gault, 387 U.S. 1 (1967).

Could it be possible that procedures, which could not be used to deprive a mother of welfare, could be used to exclude her from the protection of the U.S.Constitution so that she could be killed with impunity from criminal laws? This is preposterous.

The Constitution would not permit any court to condemn even one single Jew to death in a criminal case, but deny any of these procedural rights. Then neither can it permit any court to condemn all Jews in the United States to death, but deny any of these procedural rights, by calling it a civil proceeding, and decreeing the lives of all Jews are not protected by the U.S. Constitution, and it is "liberty" to kill all Jews with impunity from criminal laws.

Any victim is entitled to all these procedural protections before any court can decree that the victim's life is not protected by the Constitution, and the victim can be killed with impunity from criminal statutes. The rule for one is the rule for all; these are the sacred truth-seeking procedures which protect the lives of all Americans.

deny this right are guilty of crime.[4] This denial makes Roe v. Wade void.

2.

THIS COURT EFFECTED THE ROE v. WADE KILLINGS BY UNCONSTITUTIONALLY REFUSING TO ALLOW PRIOR NOTICE OF THE CONSTITUTIONAL STANDARDS, THE BURDENS OF PROOF, OR THE EVIDENCE WHICH IT USED TO INFER THAT THAT THE LIVES OF THE UNBORN ARE NOT PROTECTED BY THE U.S. CONSTITUTION.

The District Court in Roe v. Wade did not even look to see if the lives of the unborn were protected by the Constitution. This question was argued for the first time after the case reached this Court. Since this Court had never previously excluded anyone from the protection of the U.S. Constitution so they could be killed with impunity from criminal statutes, the parties had no prior notice of the factual and legal bases for such an exclusion.

Moreover in the aftermath of Dred Scott v. Sanford, legitimate public

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4. "Even judges ... could be punished criminally for willful deprivations of constitutional rights." Imbler v. Pachtman, 424 U.S. 409 (1976).

expectation rested on the assurance that this Court would never again attempt another exception to the universal terms "any person."[5]

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5. This Court's decision in Dred Scott v. Sanford appears to be the only precedent in American history in which this Court has implied an exception to the universal terms "any person" in the Fifth or Fourteenth Amendments. The Court there ruled that the universal words "any person" did not include Negroes, there was a constitutional right to own a slave, and Congress could not prohibit slavery in the free territories. This decision triggered a civil war. Candidate Abraham Lincoln vowed he would not obey Dred Scott. Opponents said their states would withdraw from the Union rather than be deprived of their assumed constitutional right to own slaves and take them to the free territories. 4 Collected Works of Abraham Lincoln 267 (1953). But President Abraham Lincoln responded that if he were bound by Dred Scott, "the people will have ceased to be their own rulers." Id., at 268. Thus the war commenced.

A purpose of the Fourteenth Amendment was to overrule Dred Scott, and place it beyond the power of judges to ever again produce convulsions by implying an exception the universal words "any person." For over a century legitimate public expectation rested on the assurance that this Court would never again attempt an exception to the universal terms "any person."

But without any prior notice, this Court once again, in the precise manner of Dred Scott, attempted to imply an exception to the universal words "any person." In Roe v. Wade, this Court thus combined both total surprise and violent defiance of the long standing legitimate public expectation that never again would this Court violate the universal words "any person."

In particular, this Court gave the parties in Roe v. Wade no prior notice of the constitutional standards, the burdens of proof, or the evidence, which the Court used to infer that the universal words "any person," as used in the Fourteenth Amendment, did not include the unborn.

The first time the parties had notice was when Roe v. Wade was published, and the victims were already condemned to death. An original party objected that it lacked the prior notice needed to defend the unborn:

> (N)ot only did the Court set a new constitutional standard, but at the same moment the Court applied the standard without giving the Appellees notice or opportunity to present evidence with respect to the point in gestation at which such standards, if they be correct as a matter of law in the first place, should be applied. "Viability", "meaningful life" or existence, "fetal life": all presumably have medical meaning which should be subject to medical testimony before a decision of constitutional import becomes solidified in concrete. These concepts are not even necessarily the appropriate ones.[6]

But this Court refused to allow the original parties to have prior notice. Thus the killings commenced.

And this Court has maintained the killings despite repeated objections that the unborn had no prior notice in Roe v. Wade of the factual and legal basis needed to defend the unborn's right to life under the U.S. Constitution.[7]

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6. Petition for Rehearing 6, Doe v. Bolton, 410 U.S. 179 (1973), denied 410 U.S. 959 (1973). (emphasis added).

7. See cases in note 2, supra.

The unborn have a constitutional right to prior notice of all the factual and legal bases before they can be excluded from the protection of the Constitution so they can be killed with impunity from criminal statutes.[8] Judges who willfully deny this right are guilty of crime.[9] This denial makes Roe v. Wade void.

3.

THIS COURT EFFECTED THE ROE v. WADE KILLINGS BY UNCONSTITUTIONALLY USING A SECRET EVIDENTIARY PROCESS TO FIND EVIDENCE TO INFER THAT THE LIVES OF THE UNBORN ARE NOT PROTECTED BY THE U.S. CONSTITUTION.

This Court used some secret evidentiary process, not open to the parties, to find evidence to infer that the lives of the unborn were not protected by the U.S. Constitution. The Court conducted these evidentiary proceedings in its back rooms; the parties were not allowed to be present; no public record was made of these proceedings. The purpose of these

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8. See note 3, supra.

9. See note 4, supra.

proceedings was to find evidence to infer that the lives of the unborn were not protected by the U.S. Constitution. An original party objected to these secret judicial proceedings:

> The Court has taken judicial notice of innumerable facts and factors, some which are expressly referred to in the Court's decision and some which are unknown to the parties but which apparently were extricated from various sources by the Court's diligent research, which facts nevertheless should be subject to refutation and counter-evidence since they form the foundation for the Court's opinion ... of constitutional stages of fetal growth.[10]

But the Court permitted the killings to commence despite this objection to its secret evidentiary proceedings.

And this Court has maintained the killings despite repeated objections that it used secret evidentiary proceeding in Roe v. Wade.[11]

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10. Petition for Rehearing 4, Doe v. Bolton, 410 U.S. 179 (1973), denied 410 U.S. 959 (1973).

11. See cases in note 2, supra.

The unborn have a constitutional right not to be excluded from the protection of the U.S. Constitution by secret evidentiary proceedings.[12] Judges who willfully deny this right are guilty of crime.[13] This denial makes Roe v. Wade void.

4.

THIS COURT EFFECTED AND MAINTAINED THE ROE v. WADE KILLINGS BY UNCONSTITUTIONALLY REFUSING TO ALLOW ITS EVIDENCE, WHICH IT USED TO INFER THAT THE LIVES OF THE UNBORN ARE NOT PROTECTED BY THE U.S. CONSTITUTION, TO BE CONFRONTED AND CROSS-EXAMINED.

Since the Court used a secret process, the original parties had not seen all the evidence which the Court used to infer that the lives of the unborn are not protected by the U.S. Constitution. An original party asked permission to cross-examine the evidence which the Court used to infer that the lives of the unborn were not protected by the U.S. Constitution:

> The Court has taken judicial notice of innumerable facts and factors, some

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12. See note 3, supra.

13. See note 4, supra.

> which are expressly referred to in the Court's decision and some which are unknown to the parties but which apparently were extricated from various sources by the Court's diligent research, which facts nevertheless should be subject to refutation and counter-evidence since they form the foundation of the Court's opinion ... of constitutional stages of fetal growth.[14]

But the Supreme Court refused to allow the original parties to cross-examine its evidence in Roe v. Wade, which it used to infer that the lives of the unborn were not protected by the U.S. Constitution. Thus the killings commenced.

And this Court has maintained the killings by steadfastly refusing to allow its evidence, which it used to infer that the lives of the unborn were not protected by the U.S. Constitution, to be confronted and cross-examined.[15]

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14. Petition for Rehearing 4, Doe v. Bolton, 410 U.S. 179 (1973), denied 410 U.S. 959 (1973) (emphasis added).

15. See cases in note 2, supra.

The unborn have a constitutional right to confront and cross-examine the evidence which this Court used to infer that their lives are not protected by the U.S. Constitution.[16] Judges who willfully deny this right are guilty of crime.[17] This denial makes Roe v. Wade void.

5.

THIS COURT EFFECTED AND MAINTAINED THE ROE v. WADE KILLINGS BY UNCONSTITUTIONALLY REFUSING TO ALLOW EVIDENCE TO BE PRESENTED ON BEHALF OF THE UNBORN TO ESTABLISH THEIR RIGHT TO LIFE UNDER THE U.S. CONSTITUTION.

In Roe v. Wade, the Court invented new constitutional standards on the protection of life by the U.S. Constitution, which the parties did not see until after Roe v. Wade was decided. The parties never had opportunity to present evidence under these new standards. An original party asked permission to present evidence under the new constitutional standards, which it had not seen before, to show that the lives of

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16. See note 3, supra.

17. See note 4, supra.

the unborn are protected by the

Constitution:

> We are dealing here with a procedure long considered outlawed and which has suddenly become become legal.
> ....
> What the Court has done is to compel the State to condone the killings of prenatal infants and even to encourage it by loose controls.
> ....
> The interest in protecting the concept of the sacredness of human life and the natural rights which follow its emergence, underlies the interest in protecting fetal life and is the root of the State's expressed desire to curb killing.
> ....
> The Court has selected a point in time at which states may protect fetal life, without any record of facts upon which to base the conclusion that only at "viability," as that term is defined by the Court, do the people of a state have authority to demand caution before a prenatal infant is destroyed.
> ....
> Appellees have had no opportunity to show by evidence in a traditional judicial trial setting at what gestational stage the separate life of the fetus is "meaningful" medically; in addition, the Court overlooked the significance of Georgia's legal recognition of meaningful human life as found in case law and statute.
> ....
> With no opportunity for Appellees to demonstrate the factual basis, in terms of current medical science, that its interest attaches at a particular

point in the natural development of a human fetus, the Court has seized upon the convenient point of "viability" and crystallized constitutional command which bars State action.

....

In the medical concept of "life," with its current body of technological knowledge, including such advances as fetal electrocardiography and fetal electroencephalography, legal "life" should not be cemented at an event in a judicial conclusion which does not have the benefit of medical evidence.

....

At any rate, Appellees should have an opportunity to present evidence and testimony to support the State's claim of medically and scientifically sound interest in requiring a cautious approach to the extinguishment of fetal life.[18]

But the Court refused to allow the original parties to present evidence to show that the lives of the unborn were protected by the U.S. Constitution. Thus the killings commenced.

And this Court has maintained the killings by steadfastly refusing to allow evidence to be presented on behalf of the

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18. Petition for Rehearing 3,4,5,6,8, Doe v. Bolton, 410 U.S. 179 (1973), denied 410 U.S. 959 (1973).

unborn to prove that their lives are protected by the Constitution.[19]

The unborn have a constitutional right to present evidence in this case to prove that their lives are protected by the U.S. Constitution.[20] Judges who willfully deny this right are guilty of crime.[21] This denial makes Roe v. Wade void.

The procedures used by the Court to effect and maintain the Roe v. Wade killings are essentially the same procedures cited by the Nuremberg Court as part of the evidence to convict the Nazi judges of complicity in extermination and murder.[22]

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19. See cases in note 2, supra.

20. See note 3, supra.

21. See note 4, supra.

22. "In many instances they were denied the right to introduce evidence, to be confronted by witnesses against them.... They were ... denied the right of counsel of their own choice....(T)he accused learned only a few moments before trial of the nature of the alleged crime for which he was to be tried. The entire proceedings from beginning to end were secret and no

II.
ISSUES RAISED BY COUNSEL NOT RAISED BY THE PARTIES

The parties have not raised the question of whether this Court must overrule Roe v. Wade because the lives of the unborn are protected by the U.S. Constitution.

The unborn have a right to be especially represented by counsel, to present evidence and arguments not presented by the parties, to show that the universal and unalienable guarantee of life to "any person," made in the U.S. Constitution, does include the unborn.[23]

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public record was allowed to be made of them." United States v. Altstoetter, 3 Trials of War Criminals Before the Nuernberg Military Tribunals 1046-1047 (1951).

"Such a mock trial is not a judicial proceeding but a murder." Id., at 1164.

"The dagger of the assassin was concealed beneath the robe of the jurist." Id. at 985.

23. This evidence and arguments are presented in the amicus curiae brief by the Legal Defense For Unborn Children, and incorporated herein by reference.

CONCLUSION

The photograph on the last page shows a child killed by a second stage abortion under Roe v. Wade. These children are entitled to have assistance of counsel to prove that the universal guarantee of life to "any person," made by the U.S. Constitution, includes the unborn.

When judges use the above procedures to defy the guarantee of life to "any person" in order to exclude millions of victims from the protection of the U.S. Constitution, so they can be killed with impunity from criminal statutes, it cannot be pretended it is any longer the government of the United States, or any government of Constitution and laws. "Such a mock trial is not a judicial proceeding but a murder."

This Court, and all the lower judges who have upheld this Court's claim of power to use such procedures to condemn millions

to death, are accused of premeditated capital mass murder.[24] "The dagger of the assassin was concealed beneath the robes of the jurist."

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24. U.S. DISTRICT JUDGES: Albert V. Bryan, Jr.; Emmett R. Cox; Edward T. Gignoux; Harold H. Greene; J. Thomas Greene; William B. Hand; Joseph C. Howard; Martin F. Loughlin; Robert Earl Maxwell; Louis F. Oberdorfer; Raymond J. Pettine; Aubrey E. Robinson, Jr.; John J. Sirica; James R. Spencer; James C. Turk; D. Dortch Warriner; Don J. Young. U.S. CIRCUIT JUDGES: D.C. Circuit- David L. Bazelon; Carl McGowan; Roger Robb; George E. MacKinnon; Spotswood Robinson III; J. Skelly Wright; Edward A. Tamm; Malcolm R. Wilkey. First Circuit- Levin H. Campbell; Frank M. Coffin; Hugh H. Bownes; Stephen G. Breyer. Fourth Circuit- Harrison L. Winter; Donald S. Russell; H. Emory Widener, Jr.; Kenneth K. Hall; James D. Phillips, Jr.; Fracnis D. Murnaghan, Jr.; James M. Sprouse; Sam J. Ervin, II; Robert F. Chapman. Eleventh Circuit- John C. Godbold; Paul H. Roney; Gerald B. Tjoflat; James C. Hill; Peter T. Fay; Robert S. Vance; Phyllis A. Kravitch; Frank M. Johnson, Jr.; Albert J. Henderson, Jr.; Joseph W. Hatchett; R. Lanier Anderson, III; Thomas A. Clark. AND the judges in Roe v. Wade and Doe v. Bolton who decreed a "liberty" to kill the unborn without any investigation to see if their lives were protected by the Constitution: Circuit Judges Morgan and Goldberg; District Judges Smith, Henderson, Hughes and Taylor.

Alan Ernest
Counsel for Movant

MOTION

MOTION FILED
AUG 16 1989

No. 88-790, No. 88-805, No. 88-1125

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM 1989

No. 88-790

TURNOCK v. RAGSDALE

ON CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE EIGHTH CIRCUIT

No. 88-805

OHIO v. AKRON CENTER FOR
REPRODUCTIVE HEALTH

ON APPEAL TO THE UNITED STATES COURT OF
APPEALS FOR THE SIXTH CIRCUIT

No. 88-1125

HODGSON v. ILLINOIS

ON APPEAL TO THE UNITED STATES COURT OF
APPEALS FOR THE SEVENTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE WITH BRIEF BY LEGAL DEFENSE FOR UNBORN CHILDREN

ALAN ERNEST
COUNSEL FOR AMICUS

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MOTION FOR LEAVE TO FILE

Interest of Amicus

The brief, which does not support any party, defends the constitutional right to life of the unborn, which the parties have not done.

Argument

The amicus proves that the the Fifth and Fourteenth Amendments' guarantee of life to "any person" does include the unborn. Thus this Court must not only overrule Roe v. Wade, 410 U.S. 113, it must rule that the States have a duty to protect unborn life. The parties have not raised this issue; it disposes of all issues in this case.

The universal guarantee of life to "any person" is the most important right in the Constitution, and the lives of millions of children depend on their being permitted to present all relevant evidence to prove their unalienable right to life.

Alan Ernest, Counsel

Contents

Interest of Amicus Curiae.....1

Summary of Argument.....1

Argument

I.

THE UNALIENABLE GUARANTEE OF LIFE TO "ANY PERSON" DOES INCLUDE THE UNBORN.

1. THE LETTER OF THE LAW (THE GUARANTEE OF LIFE TO "ANY PERSON," THE TWO MOST IMPORTANT WORDS EVER ENACTED INTO LAW) ON ITS FACE INCLUDES THE UNBORN.....1

2. THE MODIFIER "ANY" INVOKES A VIRTUALLY IRREBUTTABLE PRESUMPTION THAT THE UNALIENABLE GUARANTEE OF LIFE TO "ANY PERSON" DOES INCLUDE THE UNBORN.....4

3. THE SPIRIT OF THE LAW, THE PROMISE THAT "ALL MEN ARE CREATED EQUAL," SHOWS THE UNALIENABLE GUARANTEE OF LIFE TO "ANY PERSON" DOES INCLUDE THE UNBORN.....5

4. HISTORY SHOWS THE UNALIENABLE GUARANTEE OF LIFE TO "ANY PERSON" DOES INCLUDE THE UNBORN.....6

II.

ROE v. WADE IS VOID BECAUSE IT CRIMINALLY DEFIED THE UNALIENABLE GUARANTEE OF LIFE TO "ANY PERSON" AND CONDEMNED TO DEATH MILLIONS OF VICTIMS WHOM THE CONSTITUTION ENDEAVORS TO PRESERVE.

1. ROE v. WADE CRIMINALLY DEFIED THE UNALIENABLE GUARANTEE OF LIFE TO "ANY PERSON" BECAUSE THIS COURT DECREED KILLINGS TO BE "LIBERTY" WHICH THE PEOPLE HAD DEFINED TO BE "MURDER." THE COURT DECREED "MASS MURDER IS LIBERTY." 10

2. ROE v. WADE CRIMINALLY DEFIED THE UNALIENABLE GUARANTEE OF LIFE TO "ANY PERSON" BECAUSE THIS COURT FABRICATED EVIDENCE TO FALSELY IMPLY THAT THE WORDS "ANY PERSON" DO NOT INCLUDE THE UNBORN.....23

3. ROE v. WADE CRIMINALLY DEFIED THE UNALIENABLE GUARANTEE OF LIFE TO "ANY PERSON" BECAUSE THIS COURT DEFIED THE RULINGS OF JOHN MARSHALL AND USED A "GUILTY UNTIL PROVEN INNOCENT" BURDEN OF PROOF TO IMPLY THAT THE WORDS "ANY PERSON" DO NOT INCLUDE THE UNBORN...39

4. ROE v. WADE CRIMINALLY DEFIED THE UNALIENABLE GUARANTEE OF LIFE TO "ANY PERSON" BECAUSE THIS COURT USED "IRON CURTAIN" PROCEDURES TO IMPLY THAT THE WORDS "ANY PERSON" DO NOT INCLUDE THE UNBORN; IT USED THESE PROCEDURES TO MAINTAIN ITS ROE v. WADE KILLINGS...47

5. DUE PROCESS OF LAW HAS COMPELLED THE U.S. SUPREME COURT TO CONFESS IN COURT THAT IT IS GUILTY OF MASS MURDER, AND TO ADMIT THAT THE UNALIENABLE GUARANTEE OF LIFE TO "ANY PERSON" DOES INCLUDE THE UNBORN.....54

Conclusion.....64

TABLE OF AUTHORITIES

Cases:

Baxter v. Palmigiano, 425 U.S. 308.....56

Clarke v. State, 117 Ala. 1 13,14

Cohens v. Virginia, 6 Wheat. 264 41,54

Craig v. Missouri, 3 Pet. 410 22

Dartmouth College v. Woodward,
4 Wheat. 518.....40

Dred Scott v. Sandford, 19 How. 393.....6-8

Ernest v. U.S. Attorney, etc., cert.
denied 89 L Ed 2d 721 (1986).....21

Goldberg v. Kelly, 397 U.S. 254.....51

Gulf, Colo. and S. Fe RR v. Ellis,
165 U.S. 150.....5

Hamilton v. United States,
26 App. D.C. 382.....13

Imbler v. Pachtman, 424 U.S. 409.....51

In Re Gault, 387 U.S. 1.....51

Lamb v. State, 67 Md. 524 24

Marbury v. Madison, 1 Cranch 137.....57

Martin v. Hunter's Lessee,
1 Wheat. 305 41

McCulloch v. Maryland, 4 Wheat. 316.....55

Mills v. Comm. 13 Pa. 631 24,34

Ogden v. Saunders, 12 Wheat. 213 54

Passenger Cases, 7 How. 282.....58

Pollard v. Dwight, 4 Cranch 421.....15

Porter v. Lasiter, 87 S.E. 2d 100 14

Regina v. West, 2 C & K 784.....12-13

Ross v. Oregon, 227 U.S. 150.....62

Santa Clara v. So. Pac. RR,
118 U.S. 394.....39

Smith v. State, 33 Me. 48.....30

State v. Anderson, 343 A. 2d 505 15

State v. Reed, 45 Ark. 333 24

State v. Slagle, 83 N.C. 544 24

Sturges v. Crowninshield,
4 Wheat. 122.....40

United States v. Altstoetter, 3 Trials
of War Criminals before the Nuernberg
Military Tribunals (1951).....20,50,62

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422 U.S. 171.....56,58

Yick Wo v. Hopkins, 118 U.S. 356.....39

Texts:

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Procedure, Pleading and Evidence
(1860).....13

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Transformation of the Fourteenth
Amendment (1977).....52

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Criminal Law (4th ed. 1865).....14

Black's Law Dictionary 45

Blackstone, Commentaries.....11,23,63

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of Midwifery (1808).....26,27

Hawkins, Pleas of the Crown.....11

Hodge, Principles and Practice
of Obstetrics (1860).....27,34,35

Holmes, The Common Law (1963).....63

McCormick, The Law of Evidence (1972)....56

Model Penal Code.....62

Orwell, 1984 (1949).....19

Perkins, Criminal Law
(2d ed. 1969).....14,57,62

Plato (Jowett transl. 1942).....56

Ramsbotham, Principles and Practice of
Obstetric Medicine (1856).....27

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Misdemeanors (4th ed. 1865) 13

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States: Civil Rights (1970).....8

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in America (1860).....31

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Wigmore, Evidence (Chadborn Rev. 1972)...56

Writings of Thomas Jefferson (A. Bergh ed. 1907).....12

Articles, Reports & Briefs:

Amicus Curiae Brief by the Legal Defense Fund for Unborn Children, filed in Akron v. Akron Center for Reproductive Health, 462 U.S. 416 (1983).....60

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Hearings on the Proposed Constitutional Amendments on Abortion, Before the Subcommittee on Civil and Constitutional Rights of the Committee of the Judiciary, House of Representatives, 94th Cong., 2d Sess., Ser. 46, Part 1 (1976).....17

Jeffries and Edmonds, Abortion: The Dreaded Complication, The Philadelphia Inquirer, August 2, 1981 17

Joynes, Va. Med. J. (1856).....33

Landers, To a Traditionalist, Mr. Ron Sounds So Good, Wall Street Journal.....52

Quay, Justifiable Abortion, Medical and Legal Foundations, 49 Geo. L.J. 395 23

Transactions of the American Medical Association (1860).....34

U.S. Constitution and Statutes:

Fourteenth Amendment- "Any Person".....1-9

Fifth Amendment- "Any Person".....1-9

Fifth Amendment- Due Process 47-53

18 U.S.C. § 242 64

Interest of Amicus

The amicus defends the right to life of the unborn, which the parties have not done.

Summary of Argument

The unalienable guarantee of life to "any person," made in the Fifth and Fourteenth Amendments, includes the unborn.

Argument

I.

THE GUARANTEE OF LIFE TO "ANY PERSON," MADE BY THE CONSTITUTION, INCLUDES THE UNBORN.

1. THE LETTER OF THE LAW (THE GUARANTEE OF LIFE TO "ANY PERSON," THE TWO MOST IMPORTANT WORDS EVER ENACTED INTO LAW) ON ITS FACE INCLUDES THE UNBORN.

The 5th and 14th Amendments guarantee that not "any person" can be deprived of "life ... without due process of law." The words "any person" are universal, admit of no exceptions for anyone, make no distinction between born and unborn life, and thus on their face include the unborn, the same as everyone else. The obvious purpose of guaranteeing life universally to "any person" was to forbid making exceptions so some persons could be exterminated.

The Court admitted that if the word "person" included the unborn, then Roe v. Wade "collapses," because the unborn's lives would be "guaranteed" by the Constitution.[1] In ruling "the word 'person' ... does not include the unborn,"[2] the Court hit the Constitution head on, did what is expressly forbidden, and directly defied the letter of the law of its most important guarantee.

The words "any person" are the two most important words ever written into law. The guarantee of life to "any person" is the single most important guarantee because it protects the lives of everybody from government sanctioned extermination, as happened in Nazi Germany.

And the words "any person" give legal body to the spirit that "all men are created equal" and endowed with an "unalienable" right to life. The words "any person" exactly summarize what America stands for,

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1. Roe v. Wade, 410 U.S. at 156-157.
2. Roe v. Wade, 410 U.S. at 158.

its unique contribution to civilization. As Abraham Lincoln said, what made America great was the promise "not alone to the people of this country, but hope to the world for all future time ... that ALL should have an equal chance."

The words "any person" are the very words which guarantee that equal chance to "ALL"; they stand as the supreme political achievement of the human race, the prize of milleniums of struggle. If the Constitution had stated it protected the life of "any person - except the unborn," then its words would support Roe v. Wade. But its words say "any person," without any exceptions at all.

The Supreme Court of West Germany held that the words, "Everybody has the right to life," did include the unborn; it explained that the word "everybody" is universal.[3]

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3. R. Destro, Abortion and the Constitution The Need For A Life Protective Amendment, 63 Cal. L. Rev. at 1341-51 (1975). In 1975 the Supreme Court of West Germany ruled that the phrase in its Constitution, "Everybody has the right to life," did include the unborn, that "Abortion is an act of homicide," and

The Constitution extends its guarantee of life to "any person." The letter of the law permits no exceptions; on their face the words "any person" do include the unborn.

2. THE MODIFIER "ANY" INVOKES A VIRTUALLY IRREBUTTABLE PRESUMPTION THAT THE GUARANTEE OF LIFE TO "ANY PERSON" INCLUDES THE UNBORN.

The Court never studied the letter of the law - the universal words "any person." Instead the Court focused on the isolated word "person," and ignored its modifier "any," which invokes a virtually irrebuttable presumption in favor of life that the words "any person" do include the unborn.[4]

By reading the guarantee of life to "any person" as if it merely said "some persons," the Court did the most forbidden

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the state had a "duty ... to protect unborn life." It noted "Everybody" is universal:

> The right to live is guaranteed to everybody who is "alive." No distinction can be made among the several stages of developing life before birth, or between prenatal or postnatal life. "Everybody" ... means every "living person,"... therefore, "everybody" in this sense also includes unborn human beings.

4. See burden of proof, infra p. 39.

thing and reduced to nothing what is deemed the most important law in the history of political institutions.

3. THE SPIRIT OF THE LAW, THAT "ALL MEN ARE CREATED EQUAL," SHOWS THE GUARANTEE OF LIFE TO "ANY PERSON" INCLUDES THE UNBORN.

Roe v. Wade violates the spirit of the law, as well as its letter. The promise that "all men are created equal" and endowed with an "unalienable" right to "life" is the guiding spirit of American law. The Supreme Court itself ruled it is the spirit of the Fourteenth Amendment:

"The first official action of this nation declared the foundation of government in these words: 'We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are life...' While such declaration of principles may not have the force of organic law ... yet the latter is but the body and the letter of which the former is the thought and the spirit, and it is always safe to read the letter of the Constitution in the spirit of the Declaration of Independence. No duty rests more imperatively upon the courts than ... to secure the equality of rights which is the foundation of free government." Gulf, Colo. & S. Fe Ry v. Ellis, 165 U.S. at 159-160 (1896).

There is no real medical dispute that the unborn have been created.[5] Reading the letter of the Constitution, the guarantee of life to "any person," in the spirit that "all" are "created equal," and "all" shall get their equal chance to live, proves that the words "any person" do include the unborn. Concerning the right to life, the unborn are the equal of anyone.

4. HISTORY SHOWS THE GUARANTEE OF LIFE TO "ANY PERSON" DOES INCLUDE THE UNBORN.

The last time this Court attempted to imply an exception to the words "any person" was Dred Scott v. Sandford, 19 How. 393 (1857). The 13th and 14th Amendments were intended to overrule this decision that the words "any person," as used in the 5th Amendment, did not include Negroes; there was a constitutional right to own a slave; the phase "all men are created equal" did

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5. The uncontradicted medical evidence in the Texas brief in Roe v. Wade showed the fetal heart begins "pulsations at 24 days"; and "brain waves have been noted at 43 days"; and the unborn child is "alive."

not include Negroes; Congress could not prohibit slavery in the territories; and Negroes could not sue in federal court to see if they were slave or free.

Abraham Lincoln was a leading opponent of Dred Scott. If officials can say all men are created equal except Negroes, he asked, "where will it stop?" He denounced Dred Scott as based on "falsehood," and he alleged a conspiracy by the U.S. Supreme Court, two Presidents, and leading members of Congress, to make slavery legal everywhere and overturn the foundation of our government. Explaining why he would not obey it, President Lincoln said that Dred Scott resulted in "the rule of minority, as a permanent arrangement" which was "wholly inadmissible" and if the President were bound by Dred Scott, "the people will have ceased, to be their own rulers."

Dred Scott triggered a civil war, and President Lincoln defied the Court's decision, that there was a constitutional

right to own a slave, when he emancipated slaves and declared them to be "forever free." He reminded us at Gettysburg that we were fighting to see whether a nation dedicated to the principle that "all men are created equal" could "long endure."

The Fourteenth Amendment was intended to rededicate this nation to this original proposition. One of its framers explained:

> "It establishes equality before the law, and it gives to the humblest ... the most despised ... the same protection before the law as it gives to the most powerful.... Without this ... there is no republican government." Rep. Jacob Howard, quoted in 1 B. Schwartz, Statutory History of the United States: Civil Rights 262 (1970).

The framers intended to prevent another Dred Scott catastrophe of judges ever again implying exceptions to the words "any person" to exclude anyone; they employed the universal words most suited for this purpose. And the people had already enacted criminal abortion laws to protect all stages of unborn life, showing the guarantee of life to "any person" means what it says.

Roe v. Wade is simply another Dred Scott disaster which rests on historical contradictions so insane that to permit it is to confess that men cannot be governed by truth, reason, or laws.[6] The Court did the most forbidden thing, and defied the "unalienable" guarantee of life to "any person," the two most important words ever written into law.

The letter of the law, its spirit, its history, its presumption in favor of life, the medical facts known to the 19th century, as well as the 20th, unite to permit only one lawful conclusion: the guarantee of life to "any person" does include the unborn.

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6. Roe v. Wade rests on the contradiction that without one word of explanation, the framers intended their very promise of life to all, to "any person," to sweep away all their abortion statutes, and make killings, which they had already condemned as criminal, a fundamental "liberty" ranked along with free speech. Roe v. Wade further pretends that the framers somehow silently connived to repudiate a major point of the civil war, so that, in the manner of Dred Scott, judges would be at liberty to again produce more convulsions by implying more exceptions to the words "any person."

II.

ROE v. WADE IS VOID BECAUSE IT CRIMINALLY DEFIED THE UNALIENABLE GUARANTEE OF LIFE TO "ANY PERSON" AND CONDEMNED TO DEATH MILLIONS OF VICTIMS WHOM THE CONSTITUTION ENDEAVORS TO PRESERVE.

1.

ROE v. WADE CRIMINALLY DEFIED THE GUARANTEE OF LIFE TO "ANY PERSON" BECAUSE THIS COURT DECREED KILLINGS TO BE "LIBERTY" WHICH THE PEOPLE HAD DEFINED TO BE "MURDER." THE COURT DECREED "MASS MURDER IS LIBERTY."

When the Fourteenth Amendment was adopted in 1868, an abortion was murder if the child was "born alive." And a child could be "born alive" long before the Court's arbitrary point of "viability."[1]

An 1859 study by the American Medical Association stated the law of murder throughout the United States:

> If a person, intending to procure abortion, does an act which causes the

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1. This Court arbitrarily set the point, where the law could begin to protect the unborn, at "viability" (about 7 months gestation) "because the fetus then presumably has the capability of meaningful life outside the ... womb." Roe v. Wade, supra, 163. The point is arbitrary, because the Court cannot explain why (in legal and medical precedent) it can be criminal to kill the unborn a few days after viability, but must be "liberty" to kill the unborn a few days before. The Court invented it.

> child to be born earlier than its natural time, and therefore in a state much less capable of living, and it afterwards die in consequence of such premature exposure, the person who by this misconduct brings the child into the world, and puts it into a situation in which it cannot live, is guilty of murder.[2]

Yet in 1973, without any investigation of the law of murder, the Court decreed this very killing to be "liberty" which the American people had universally defined to be "murder." In plainest terms, the Supreme Court decreed: "MASS MURDER IS LIBERTY."

A. THE ENGLISH COMMON LAW WAS THE LAW OF THE LAND IN COLONIAL AMERICA

America's first settlement at Jamestown followed the English common law, as did other colonies. The common law defined an abortion in which a "quick" (about 4 months gestation) child died after being "born alive" to be "murder."[3] So if

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2. Reported in A.S. Taylor, A Manual of Medical Jurisprudence 462 (6th ed. 1866). He described the AMA report as "a complete and comprehensive exhibit of laws of each of the United States." Id., at 460.

3. Coke, 3 Inst. 50; Hawkins, 1 Hawkins Ch. 13, s. 16; Blackstone, 4 Bl. Com. 198.

the child were "born alive" (even if not "viable"), Coke said the abortion is "so horrible an offense" and "this is murder."[4]

Regina v. West involved this very abortion of a quick, but pre-viable child:

> "The prisoner is charged with murder; and the means stated are, that the prisoner caused the premature delivery ... by using some instrument for the purpose of procuring abortion; and that the child so prematurely born was, in consequence of its premature birth, so weak that it died.
> ....
> "A medical witness stated ... that it was a healthy child; but that, being born at that period of gestation, it was impossible that it could live any considerable length of time separated from the womb of the mother. It was incapable of maintaining a separate and independent existence." Regina v. West, 2 C & K 784, 786-788 (1848).

Although not yet viable, the judge cited Coke and instructed the jury that if the child were "born alive," the abortion was

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4. Coke, 3 Inst. 50. "This work is executed with so much learning and judgment, that I do not recollect that a single position in it has ever been judicially denied....(I)t may still be considered as the fundamental code of the English law." 14 The Writings of Thomas Jefferson 57 (Bergh ed. 1907). Jefferson was an authority on colonial law, serving on the 1776 committee which adapted Virginia's laws to republican form, the common law being assigned to him.

murder.[6] The English writers cited this as the correct statement of the law.[7]

Thus Roe v. Wade decreed killings to be "liberty" which had been condemned as "murder" since earliest colonial times.

B. "BORN ALIVE" ABORTIONS WERE MURDER WHEN THE FOURTEENTH AMENDMENT WAS ADOPTED.

The English common law is the dictionary which courts use to construe the state and federal homicide statutes.[8]

By the time the Fourteenth Amendment was adopted, American legal authorities had

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6. Regina v. West, 2 C & K at 788: "I am of opinion (and I direct you in point of law), that if a person intending to procure abortion does an act which causes a child to be born so much earlier than the natural time, that it is born in a state much less capable of living, and afterwards dies in consequence of its exposure to the external world, the person who by her misconduct so brings the child into the world, and puts it thereby in a situation in which it cannot live, is guilty of murder."

7. 1 J.F. Archbold, A Complete Treatise on Criminal Procedure, Pleading and Evidence 783 (Waterman Am. ed. 7th ed. 1860); 1 W.O. Russell, A Treatise on Crimes and Misdemeanors 671-672 (4th ed. 1865).

8. Clarke v. State, 117 Ala. 1 (1898); Hamilton v. United States, 26 App. D.C. 382 (1905).

long followed the common law rule that abortions of pre-viable children "born alive" were murder. In 1858 the preeminent legal writer of the 19th century explained:

> "If a person intending to procure abortion, does an act which causes a [quick] child to be born so much earlier than the natural time, that it is born in a state much less capable of living, and afterwards dies, in consequence of its exposure to the external world, the person who by this misconduct, so brings the child into the world, and puts it thereby in a situation in which it cannot live, is guilty of murder" F. Wharton, A Treatise on the Law of Homicide in the United States 93 (1855).

This was the uncontradicted view in the United States when the Fourteenth Amendment was adopted.[9] Courts applied this law of murder.[10] It was still the law in 1973.[11] In 1975 the New Jersey courts

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9. 2 J.P. Bishop, Commentaries on the Criminal Law 365 (4th ed. 1868); A.S. Taylor, supra, 462, 517.

10. Clarke v. State, 117 Ala. 1 (1898). "In Georgia ... the wilful killing of an unborn child so far developed as to be ... called 'quick,' is considered as murder." Porter v. Lassiter, 87 S.E. 2d 100, 102 (1955).

11. R. Perkins, Criminal Law 30 n.17 (2d ed 1969).

applied this 17th century murder law to the killing of a pre-viable fetus born alive:

> That a fetus may be the victim of murder if it be born alive has long been a part of our common law....Coke, Institutes 58 (1648).[12]

For almost four centuries governments came and went, but the law that born alive abortions are murder, which is binding on the U.S. Supreme Court,[13] remained the law of the land.

Thus Roe v. Wade decreed killings to be "liberty" which had been universally condemned by the framers and adopters of the Fourteenth Amendment to be "murder."

C. THE GUARANTEE OF LIFE TO "ANY PERSON" INCLUDES CHILDREN GUARDED BY THE MURDER LAW

The guarantee of life to "any person" in the Fourteenth Amendment must include

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12. State v. Anderson, 343 A. 2d 505, 508 (1975), affirmed 413 A. 2d 611 (1980). The courts rejected the claim it was not murder because "the infants were never capable of maintaining a separate and independent existence." Id. at 615.

13. Chief Justice Marshall ruled that the Supreme Court must accept the construction given by a state to its own statute. Pollard v. Dwight, 4 Cranch 421, 429.

all persons whose lives were protected by the law of murder when the Amendment was adopted. No dispute is even possible.

If the killing of Jews had been defined to be murder in 1868, it is certain that the framers did not intend to exclude Jews from the guarantee of life to "any person" so it would be "liberty" to kill Jews with impunity from criminal laws. Changing the names of the victims does not change the legal result.

The people who framed and adopted the Amendment had condemned the taking of a crying, pre-viable infant from its mother's womb to be murder. Thus it is certain that they did not intend to exclude the lives of these children from the guarantee of life to "any person" so it would be "liberty" to kill them with impunity from murder laws.

By arbitrarily setting "viability" as the point the law could begin to protect unborn life, the Court decreed the same

killing to be "liberty" which the American people had condemned as "murder."

The words "any person" do indisputably include children protected by the law of murder. And since personhood under the Constitution does not just fade away with time, like some magic disappearing ink, the right to life of these children is still guaranteed by the Fourteenth Amendment.

D. ROE_v._WADE_ALLOWS_HYSTEROTOMY_ABORTIONS

Roe v. Wade hysterotomy abortions, basically Caesareans, result in children "born alive."[14] As explained to Congress:

> With few exceptions, babies aborted by this method will all move, will all breathe, and some will cry.... Almost all were born alive.[15]

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14. Jeffries and Edmonds, Abortion: The Dreaded Complication, Philadelphia Inquirer, August 2, 1981.

15. Hearings on Constitutional Amendments on Abortion, before subcomm. on Civil and Constitutional Rights, of the House Comm. of the Judiciary, 94th Cong., 2d Sess., Ser. 46, Part 1, at 397 (1976) (statement by Dr. John Willke, M.D.). There are about 140,000 second stage abortions each year. Washington Post, April 26, 1985, A11. Most methods can result in a child born alive.

When the Fourteenth Amendment was adopted, these hysterotomy abortions were murder. Thus the lives of the children are still guaranteed by the Amendment, and the killings are still murder.

F. THE DECREE "MASS MURDER IS LIBERTY" OVERTHROWS THE U.S. CONSTITUTION

Is a government of laws founded upon evidence, or the mere naked decrees of men holding office for life? The evidence proves that the lives of these children are guaranteed by the U.S. Constitution.

This evidence for the unborn is exactly the same evidence which many people must rely upon to prove their lives are guaranteed by the U.S. Constitution.[16] If

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16. Suppose it were claimed in federal court that it is "liberty" to kill the insane, or invalids, or Jews. What factual, non-argumentative evidence could be found to establish their right to life under the U.S. Constitution?
As with the unborn, it would do no good to object that no one ever heard of a "liberty" to kill them - or to object that such killings had thereto been criminal.
The Amendment merely states that it protects the life of "any person." So, as with the unborn, it does not expressly

the evidence is ineffective for the unborn, then the Roe v. Wade precedent can grow to a "liberty" to kill virtually anyone. If the Supreme Court decreed it "liberty" to kill Jews, this same evidence would prove it "murder," and not "liberty." Judges may have more sympathy for other victims, but changing the names of the victims will not change the legal result.

Roe v. Wade murders reason itself. In his novel, "1984," Orwell described how a tyranny defrauded its subjects into obedience with the "doublethink" slogan "FREEDOM IS SLAVERY." Although this science fiction appears improbable, the U.S. Supreme Court has defrauded the United

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refer to them; and its legislative history does not appear to expressly refer to them.

The principle that all people are "created" equal, with an "unalienable" right to "life," having been sneered out of court in Roe v. Wade, now provides no assurance for anyone.

As with the unborn, the murder laws don't expressly refer to the insane, or invalids, or Jews; the intention of the legislators is found in the common law.

If the evidence cannot protect the unborn, the lives of many are imperiled.

States into obedience with the ultimate falsehood: "MASS MURDER IS LIBERTY."

Abraham Lincoln ridiculed Dred Scott by reducing it to its plainest terms:

> [We hold these truth to be self-evident, that] all men are created equal - except Negroes.
> That if any one man, choose to enslave another, no third man shall be allowed to object.

The Fourteenth Amendment intended to prevent this forever. Yet Roe v. Wade, reduced to its plainest terms, asserts:

> We hold these truths to be self-evident, that all men are created equal - except those created to be murdered.
> That if any one man, choose to murder another, no third man shall be allowed to object.

By changing the names of the victims, the Supreme Court has duplicated the decree of "the supreme judge" of Nazi Germany who asserted the killing of Jews to be legal.[17]

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17. United States v. Altstoetter, 3 Trials of War Criminals Before the Nuernberg Military Tribunals 1011-1014 (1951). The Nazi judges claimed that they could not be held accountable for complicity in extermination and murder, since they had acted "within the authority" of the "decrees" of "the supreme judge." Id. at

The key doctrines of the Nazi judiciary have been adopted by the courts of the United States: a "supreme judge" which decrees mass murder to be legal; and lower judges who rule they must blindly obey.[18]

The Court did exactly what the guarantee of life to "any person" was intended to prevent, and decreed murder to be legal, by giving "murder" the new name "liberty." But Chief Justice Marshall condemned such sham:

> "Is the proposition to be maintained that the Constitution meant to prohibit names and not things? That a very important act, big with great and ruinous mischief which is expressly forbidden by words most appropriate for its description; may be performed by the substitution of a name? That the Constitution, in one of its most important provisions, may be evaded by giving a new name to an old

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983-85. Their "supreme judge" had decreed killings to be legal which had been defined by statute to be criminal. But the tribunal held, "The dagger of the assassin was concealed beneath the robe of the jurist."

18. Ernest v. U.S. Attorney etc., cert. denied 475 U.S. 1084 (1986). The U.S. District Judge ruled that Roe v. Wade was "the worst decision by the Supreme Court in the history of the Court." But he stated that even if the Supreme Court decreed it liberty to kill Jews, he must obey and permit the killings to continue.

thing? We cannot think so." Craig v. Missouri, 3 Pet. at 433 (1830).

Thus the United States is ruled by the decree "MASS MURDER IS LIBERTY." But murder is still murder, no matter what new name the Court gives it. This is the most catastrophic crime in history. This precedent of judicial alchemy to convert murder into "liberty" can be evoked at whim to kill anyone; it cancels the "unalienable" guarantee of life and makes everybody a mere hostage of this Court; it is a virtual murder gun held to everyone's head - all life now depends merely on judicial whim; it defies the consent of the governed; it smashes the hopes of the whole human race for government by truth and laws, and reduces government to the mere matter of which murderer can grab power and be obeyed. Again people must struggle to ensure that the nation dedicated to the proposition that "all men are created equal" shall not "perish from this earth."

ROE v. WADE CRIMINALLY DEFIED THE UNALIENABLE GUARANTEE OF LIFE TO "ANY PERSON" BECAUSE THIS COURT FABRICATED EVIDENCE TO FALSELY IMPLY THAT THE WORDS "ANY PERSON" DO NOT INCLUDE THE UNBORN.

The 19th century abortion statutes supplanted the medieval view that unborn life began at "quickening"[1] and expanded protection of law to all stages of unborn life; they prove the guarantee of life to "any person" includes the unborn, that no distinction can be made among the stages of unborn life.

When the Fourteenth Amendment was adopted in 1868, over three-fourths of the ratifying states had already made abortion at any stage of gestation a crime.[2] Within a few years, these statutes were universal.

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1. "Life is the immediate gift of God, a right inherent by nature in every individual: and it begins in contemplation of law as soon as the infant is able to stir in the mother's womb." 1 Bl. Com. 126.

2. The statutes are set out in Quay, Justifiable Abortion, Medical and Legal Foundations, 49 Geo. L. J. 447-520 (1961).

And in those few States still following the common law, judicial revision makes it impossible for this Court to assert with any assurance that it was any different than the prevailing statutes:

> By the ancient common law ... as the life of an infant was not supposed to begin until it stirred in the mother's womb, it was not regarded as a criminal offense to commit an abortion in the early stages of pregnancy. A considerable change in the law has taken place in many jurisdictions by the silent and steady progress of judicial opinion; and it has been frequently held by Courts of high character that abortion is a crime at common law without regard to the stage of gestation.[3]

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3. Lamb v. State, 67 Md. 524 (1887). Some state supreme courts rejected medieval medical views and ruled that the common law made abortion at any stage of gestation a crime. Mills v. Comm., 13 Pa. 631 (1850); State v. Slagle, 83 N.C. 544 (1880); State v. Reed, 45 Ark. 333 (1885).

Wharton, a standard 19th century text, stated that under common law "the protection of the law was cast round an unborn child from its first stage of ascertainable existence, no matter whether 'quickening' had taken place or not." F. Wharton and M. Stille, Treatise on Medical Jurisprudence 927-28 (2d ed. 1860).

And those state supreme courts which ruled that abortion prior to quickening was not a common law crime were immediately

The theory of a "liberty" to kill the unborn faced a fatal contradiction. How could the Court dare to Dred Scott-like imply an exception to the guarantee of life to "any person" in order to declare killings to be "liberty" which the people had defined to be criminal? This absurd contradiction wrecks Roe v Wade.

To resolve this fatal contradiction the Court fabricated the hypothesis that the 19th century criminal abortion statutes were not intended to protect unborn life, but were only intended to protect the mother. This falsely implied that the people never intended the lives of the unborn to be protected by law. This false hypothesis was fabricated as follows.

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overruled by their legislatures which made abortion at any stage of pregnancy a crime. Comm. v. Parker, 50 Mass. 263 (1845), was immediately overruled by Mass. Acts & Resolves ch. 27 (1845). State v. Cooper, 22 N.J.L. 52 (1849), was immediately overruled by N.J. Laws at 266 (1849). Abrahams v. Foshee, 3 Iowa 274 (1856) was overruled by the next legislature, Iowa Rev. Laws, tit. XXIII, ch. 165. art. 2, sec. 4221 (1860).

A.

The Court first asserted as fact:

> "When most criminal abortion laws were first enacted, the procedure was a hazardous one for the woman." Roe v. Wade, 410 U.S. at 148.

The only authority cited was a 20th century medical history book.[4] But this book only described the hazards of major surgery in general prior to Lister's discovery of antiseptics; the abortion operation was not mentioned anywhere in the entire book.

The 19th century obstetric authorities throughout the Western world prove that abortions by physicians were "perfectly safe" to the woman.[5] They prove the Court's assertion of fact to be false.

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4. Haagensen and Lloyd, A Hundred Years of Medicine 19 (1943), cited in Roe v. Wade, supra, at 148 n.43.

5. 2 T. Denman, M.D., An Introduction to the Practice of Midwifery 96 (1802). He was a standard English authority. They based their judgments on their own experience in performing abortions, and from hundreds of cases reported from around the world. In addition to perforation, other procedures were also safe. A French physician wrote "experience has proved that the dangers of the operation are reduced to a small

The Supreme Court never revealed the "hazardous" abortion "procedure" to which it was referring. Actually, the 19th century physicians generally used the ancient method,[6] which one physician traced back 2000 years,[7] and which they described as "perfectly safe" to woman.

The Court did not examine even one 19th century obstetric textbook; and they prove its assertion, "the procedure was a hazardous one for the woman," to be false.

Since abortion was not dangerous to the life of the mother, the only motivating

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matter." A.L.M. Velpeau, M.D., A Complete Treatise on Midwifery 530 (4th Am. ed. 1852). The preeminent American physician wrote "to the mother there is very little danger." H.L. Hodge, M.D., The Principles and Practice of Obstetrics 293 (1864).

6. Dr. Denman, a standard authority in England, wrote in 1802: "the membranes of the ovum are punctured," which permitted "the discharge of the waters," which induced the "action of the uterus," which resulted in the expulsion of the fetus from the womb, which was "perfectly safe" to the woman. 2 Denman, supra, at 96-99.

7. F. Ramsbotham, M.D., The Principles and Practice of Obstetric Medicine 724 (4th ed. 1856).

purpose the abortion statutes could have had was to protect the lives of the unborn from destruction by abortions, even safe abortions by physicians. Had it been the purpose of the legislators to only protect the mother, they would have simply required abortions, which were known all over the western world to be safe to the mother, to be performed only by physicians.

B.

The Court next asserted: "Abortion mortality was high."[8] This is asserted as fact. The Court cited no authority to support it. The 19th century obstetric authorities prove this assertion to be false; their medical texts show that the abortion operation was "perfectly safe."

The purpose of the Court's false assertion of fact is to go beyond the mere theory that abortion was hazardous to the mother, and infer that the carnage was so

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8. Roe v. Wade, 410 U.S. at 149.

great as to call for legislation to protect women from the medical profession.

C.

Upon these two false assertions of fact, the Court next falsely inferred:

> "[A] State's real concern in enacting a criminal abortion law was to protect the pregnant woman, that is, to restrain her from submitting to a procedure that placed her life in serious jeopardy." Roe v. Wade, 410 U.S. at 149.

This is a false inference, drawn from two false assertions of fact. Moreover, the 19th century treatises on criminal law expressly stated that these abortion statutes were intended to supplant the ancient common law and protect the lives of the unborn during all stages of gestation:

> "The notion that a man is not accountable for destroying the child before it quickens, arose from the hypothesis that quickening was the commencement of vitality with it, before which it could not be considered as existing. This "absurd distinction" ... is now exploded in medicine.... The foetus is certainly ... as much a living being immediately after conception, as at any other time before delivery.
>
> ....
>
> "There is as much vitality ... on one side of quickening as on the other, and ... the infant is as much entitled to

> protection ... a week before it quickens as a week afterwards.... Acting under these views, the legislatures ... passed acts making ante-quickening-foeticide individually penal." 1 F. Wharton, A Treatise on the Criminal Law of the United States 656-57 (5th ed. 1861).

There is no 19th century authority to the contrary. If the purpose of these laws had been to protect the mother, and not the child, these texts would certainly have noted such an important thing.

And State supreme courts ruled that these statutes protected the unborn:

> "(T)he statute ... essentially changed the common law. There is a removal of the unsubstantial distinction, that it is no offense to procure an abortion, before the mother becomes sensible of the motion of the child, notwithstanding it is then capable of inheriting an estate.... It is now equally criminal to produce abortion before and after quickening." Smith v. State, 33 Me 48 (1851).

Since abortions by physicians were known all over the western world to be safe to the mother, the motivating purpose of these abortion laws could only have been to protect the lives of unborn children from destruction from abortions. That

legislatures prohibited safe abortions by physicians, despite the great danger to the mother from abortions by criminals,[9] shows their great respect for unborn life.

D.

The Court next made its irrelevant study of the single word "person," and held it "does not include the unborn":

> "(O)ur observation ... that throughout the major portion of the 19th century prevailing legal abortion practices were far freer than they are today, persuades us that the word 'person,' as used in the Fourteenth Amendment, does not include the unborn." Roe v. Wade, 410 U.S. at 158.

The Court could not find even one 19th century authority to support this result; the whole weight rests on the Court's "major portion - far freer" assertion, which is false.[10] The reverse is closer to

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9. "In thirty-four cases of criminal abortion ... twenty-two were followed...by death, and only twelve were not. In fifteen cases necessarily induced by physicians, not one was fatal." H.R. Storer, M.D., On Criminal Abortion in America 43 (1860)

10. The ancient common law only prevailed in the early 19th century. By mid-century, a majority of the States which ratified the Amendment had already enacted statutes

the truth. The evidence indicates that legal abortion was far freer in 1973, than when the Amendment was adopted.[11]

The Court's "major portion - far freer" doctrine, were it even true, is absurdly irrelevant[12] and ominously skirts

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which punished abortion throughout gestation. (Supra n.2) By 1868, over three-fourths had enacted such statutes; and shortly they were universal. In those few states with no statute, this Court cannot claim with assurance that the common law was any different. (Supra n.3) Thus the "prevailing law" for the last half of the 19th century; it was about the same as existed in most states in 1973; and "legal" abortion was not "far freer" then.

11. The statutes listed in Roe v. Wade, 410 U.S. at 140 n37, show that by 1973 four states permitted abortion on demand, while fourteen permitted abortions for other reasons not allowed in 1868. The statutes prevailing in 1868 only permitted abortions to save the life of the mother or child. Thus legal abortion was far freer in 1973 than in 1868, although in most states it was still about the same as it was in 1868.

12. The same thing could be said about "legal slavery," which really was "far freer" for the "major portion" of the 19th century than it is today. Would this prove a right to own a slave today? If the Court could ignore the events of 1860 to 1866 - it could plausibly reaffirm its Dred Scott rule that there was a right to own a slave.

the central issue of the law existing in 1868, and the reason for the vast change.

The Court's assertion that "legal abortion" was then "far freer" refers to the ancient common law that abortion prior to "quickening" was not a crime, on the theory that life began at "quickening." A physician, who helped draft Virginia's 1848 abortion statute, explained its purpose was to supplant this "exploded error":

> "(T)hat the embryo is endowed with an inherent vitality from the first moment of conception, and is therefore as much entitled to the protection of the law before the period of 'quickening' as after it, every well-informed physician must yield a ready assent. The old doctrine, once held by medical men ... that the foetus first becomes animated, or endowed with distinct vitality, at the moment when the sensation of quickening is experienced by the mother, has been long since banished from the domain of science ... and now only finds a retreat in the dark and ancient caverns of the common law.
> ....
> "(T)he civil rights of the unborn child are perfect from the very commencement of its being." L.S. Joynes, M.D., "Foetus in Utero," Virginia Medical Journal 179-180, 187 (1856).

The 19th century medical and legal authorities, with none to the contrary, condemned this ancient theory of life:

> "(I)t is the duty of every accoucheur earnestly to protest against the ancient theological and legal opinion that, prior to the fourth month, the embryo had no proper existence.... (T)he merest tyro in physiological investigations must be convinced of the falsity of all such opinions." H.L. Hodge, M.D., The Principles and Practice of Obstetrics 78 (1864).

Yet the Court exactly adopted, as constitutional law, a view of unborn life which the 1860 president of the AMA called "a barbarous physiology" and which courts ruled "never ought to have been the law anywhere,"[13] and which 19th century legislatures condemned as criminal. The AMA president said in urging States to protect all stages of unborn life:

> "This relic of a barbarous physiology needs to be exploded, and the truth should be generally promulgated, that, from the moment of conception, a new being is engendered." 13 Transaction of the American Medical Association 56-57 (1860).

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13. Mills v. Commonwealth, supra, 632.

The abortion statutes were urged by America's most eminent medical professors and physicians, and they were intended to protect all stages of unborn life:

> From the moment of fecundation, the new being becomes independent ... its individuality is complete.... (T)here is a progressive ... advancing from one degree of perfection to another. Every protection, therefore, which is extended by human legislation to the young infant ... should be equally effectual in securing the life of the embryo from the earliest period of its existence.[14]

The abortion statutes show the universal guarantee of life to "any person" was not based on "a barbarous physiology"; the Amendment recognizes that there is no time during unborn life that a rational line can be drawn to permit the killings.

But the Court accepted the medieval view, that life began at "quickening"

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14. H.L. Hodge, M.D., The Principles and Practice of Obstetrics 78 (1864). Hodge's "name had become a household word throughout the land" and his book "valued among the very first works on obstetrics ever issued from the American or foreign press." R. Penrose, M.D., Discourse on Life of H.L. Hodge 20-21 (1872)

(about 4 months), and arbitrarily enlarged it to "viability" (about 7 months), making a "liberty" to kill which even its only authority, the ancient common law, condemned as criminal. Thus the basis of the Court's decree that "the word 'person'... does not include the unborn." Thus 20th century constitutional law was founded on medieval medical theory which was rejected as false in the 19th century, and remains false today.

In short, the Court manufactured a constitutional right to kill, out of "an exploded error" that an ante-quick child was not alive, which the "merest tyro" knew to be false, and was universally condemned as "a barbarous physiology" found only in "dark and ancient caverns," which 19th century judges ruled "never ought to have been the law anywhere," and which legislatures condemned as criminal everywhere, in order to Dred Scott-like blast an exception to the guarantee of life to "any person," so

tens of millions of victims could be killed with impunity from criminal statutes. This is not law; it is murder under ruse of law.

The Court's arbitrary shopping among medieval notions, rejected by the framers as "barbarous," to define the unalienable guarantee of life to "any person," is a another murder gun precedent pointed at the head of all Americans; it makes everyone a hostage of this Court; judges can arbitrarily pull its trigger to destroy anyone.

The Court now has bloody precedent for doing the most forbidden act; it directly defied the unalienable guarantee of life to "any person," the two most important words ever written into law, and condemned to death millions of victims whom the U.S. Constitution endeavors to preserve. It can now happen to anyone; the Court has cancelled the "unalienable" guarantee of life to "ALL," and sealed it in blood.

E.

In construing its equivalent word "everybody," the Supreme Court of West Germany ruled it did include the unborn:

> "No distinction can be made among the several stages of developing life before birth, or between prenatal and postnatal life." [Supra page 3 n.3]

The history of the criminal abortion statutes proves the framers made this same conclusion when they universally guaranteed life to "any person" without any exceptions: there is no time during unborn life that the law can withdraw its protection and permit the killings; rather it is the duty of the law to protect the weak.

Without need of assistance from Chief Justice John Marshall's burdens of proof, as described in the next section, history permits only one rational conclusion: the universal and "unalienable" guarantee of life to "any person" includes the unborn during all stages of unborn existence.

3.

THIS COURT CRIMINALLY DEFIED THE UNALIENABLE GUARANTEE OF LIFE TO "ANY PERSON" WHEN IT DEFIED THE RULINGS OF JOHN MARSHALL AND USED A "GUILTY UNTIL PROVEN INNOCENT" BURDEN OF PROOF TO INFER THAT THE WORDS "ANY PERSON" DO NOT INCLUDE THE UNBORN.

The Court used the correct burden when it previously construed "any person."[1] Yet when it came to the unborn, it used a "guilty until proven innocent" burden.

A.

THE BURDENS, DESCRIBED BY CHIEF JUSTICE MARSHALL, PROVE THE GUARANTEE OF LIFE TO "ANY PERSON" DOES INCLUDE THE UNBORN.

Chief Justice John Marshall described the conditions the Court must satisfy to lawfully imply an exception to universal terms in the U.S. Constitution.

Before the Court can exclude the unborn from the guarantee of life to "any

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1. The Court properly ruled that the words "any person" included Chinese aliens, saying the words are "universal in their application, to all persons ... without regard to any differences." Yick Wo v. Hopkins, 118 U.S. 356, 369 (1886). And this Court was so sure that the words "any person" included "corporations," it refused to even allow counsel to argue against it. Santa Clara v. So. Pac. RR, 118 U.S. 394, 396 (1886).

person," so they can be killed with impunity from criminal laws, the Court must prove that including the unborn within the terms "any person" would be "so monstrous, that all mankind would, without hesitation, unite in rejecting the application."[2]

The Court must prove that if the right to life of the unborn had "been suggested [to the framers] the language would have been so varied, as to exclude it,"[3] and the

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2. Sturges v. Crowninshield, 4 Wheat. 122, 202-203 (1819). When the Constitution uses universal words, and a case is "within the very words of the Constitution," it would be "dangerous in the extreme" to infer the case "is not within its spirit" because "we believe the framers of that instrument could not intend what they say" unless the "absurdity and injustice of applying the provision to the case, would be so monstrous, that all mankind would, without hesitation, unite in rejecting the application."

3. Dartmouth College v. Woodward, 4 Wheat. 518, 644-45 (1819). "It is not enough to say that this particular case was not in the mind of the Convention, when the article was framed, nor of the American people, when it was adopted. It is necessary to go farther, and to say that, had this particular case been suggested, the language would have been so varied, as to exclude it, or it would have been made a special exception. The case being within

framers would have changed the guarantee to read: "Nor shall any state deprive any person, except unborn persons, of life ... without due process of law."

These are the burdens which protect the lives of all Americans from government sanctioned extermination, as happened in Nazi Germany; they carry the life of each American in their hands. The Court bears the heaviest burden of proof to imply an exception to the guarantee of life to "any person" so millions of victims can be killed with impunity from criminal laws.[4]

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the words of the rule, must be within its operation likewise, unless there be something in the literal construction so obviously absurd ... as to justify those who expound the constitution in making it an exception."

The Court used these burdens when it ruled it could not read its jurisdiction, which includes "all cases" arising under the Constitution, as if it merely said "some cases." Cohens v. Virginia, 6 Wheat 264 (1821); Martin v. Hunter's Lessee, 1 Wheat. at 339 (1816).

4. The truth of this extraordinary burden can be demonstrated by applying it to various cases. Before the Court could imply an exception to the universal terms "any person," so that Jews could be deliberately

Chief Justice Marshall's rules prove the guarantee of life to "any person" does include the unborn because "all mankind" would not unite "without hesitation" to exclude them. And the framers would not have changed the guarantee to read "any person - except the unborn," so it would be liberty to kill them, because the people had already enacted criminal statutes to protect the lives of the unborn by law. Thus the guarantee of life to "any person" does include the unborn.

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killed with impunity from criminal laws, the Court would have to prove that "the absurdity and injustice" of including Jews within the universal terms "any person" would be "so monstrous, that all mankind would, without hesitation, unite in rejecting the application." And the Court must prove that if the case of the Jews had been suggested to the framers, they would have changed the Amendment to read: "No state shall deprive any person, except Jews, of life without due process of law." This same burden protects us all.

B.

THIS COURT EXACTLY DEFIED THE BURDEN DESCRIBED BY CHIEF JUSTICE JOHN MARSHALL.

Instead of placing the burden on the advocates of the killings to prove that including the unborn within the guarantee of life to "any person" would "be so monstrous, that all mankind would, without hesitation, unite in rejecting the application," the Court reversed the burden:

First, the Court declared a "liberty" to kill the unborn with impunity from criminal laws, before it even looked to see if the guarantee of life to "any person" included the unborn.[5]

Second, subsequently, the Court looked to see if the guarantee of life to "any person" included the unborn.[6]

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5. Roe v. Wade, 410 U.S. at 153: "(T)he Fourteenth Amendment's concept of personal liberty ... is broad enough to encompass a woman's decision ... to terminate her pregnancy."

6. Roe v. Wade, 410 U.S. at 156-157. "The appellee ... argue that the fetus is a 'person' within the language and meaning of the Fourteenth Amendment."

Third, the Court admitted that if the words "any person" included the unborn, its predetermined assertion of a "liberty" to kill the unborn "of course, collapses."[7] But the Court decreed a "liberty" to kill the unborn before it looked to see if the unborn had a "guaranteed" right to live.

Thus the Court had passed its sentence of death, before it even looked to see if the Constitution guaranteed a right to live. It is analogous to a court sentencing an accused to be hung before it even heard the evidence. As Alice's Queen demanded: "Sentence first; verdict afterwards."[8]

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7. Roe v. Wade, 410 U.S. at 156-157: "If this suggestion of personhood is established, the appellant's case, of course, collapses, for the fetus' right to life would then be guaranteed specifically by the Amendment."

8. The vengeful Queen in "Alice in Wonderland" shouted "Off with her head" and when admonished that the jury must first consider its verdict, she said: "No! No! Sentence first- verdict afterwards."
So it was in Roe v. Wade - first the sentence of death; then the verdict whether the law allowed the victim to live.

Fourth, the Court's purpose for first predetermining a "liberty" to kill the unborn, was not only to shift the burden of proof from the advocates of the killings onto the unborn, but also to impose its heaviest "compelling" burden on the unborn, a burden of proof so devastating that state statutes seldom, if ever, survive it.[9]

Fifth, the Court stated that the evidence did not prove "with any assurance" that the guarantee of life to "any person" included the unborn.[10] This confirms that the Court placed the burden on the unborn to prove with "assurance" that the words "any person" included the unborn. This is the heaviest burden which can be imagined.

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9. Roe v. Wade, 410 U.S. at 155: "Where certain 'fundamental rights' are involved, the Court has held that regulation limiting these rights may be justified only by a 'compelling state interest.'" As its compelling state interest, Texas claimed that the lives of the unborn were protected by the Fourteenth Amendment. Id., at 156.

10. Roe v. Wade, 410 U.S. at 157. "Assurance" means: "To make certain and put beyond doubt." Black's Law Dictionary (4th ed. 1968).

Finally, by calling upon its false evidence to raise trifling doubts, the Court said that the unborn had not met their burden of proof and ruled "the word 'person' ... does not include the unborn."

If the Court used such burdens to decree a "liberty" to kill Jews, surely none would deny it would be murder. Judges may have more sympathy for other victims, but changing the name of the victims will not change the legal result.

When courts use such burdens to condemn victims to death, it can no longer be pretended it is still the government of the United States - any government of laws. This is still another "murder gun" precedent pointed at the head of every American; judges can arbitrarily use it to destroy anyone. The true burden proves beyond dispute that the guarantee of life to "any person" does include the unborn.

ROE v. WADE CRIMINALLY DEFIED THE UNALIENABLE GUARANTEE OF LIFE TO "ANY PERSON" BECAUSE THIS COURT USED "IRON CURTAIN" PROCEDURES TO IMPLY THAT THE WORDS "ANY PERSON" DO NOT INCLUDE THE UNBORN; IT USED THESE PROCEDURES TO MAINTAIN ITS KILLINGS.

The Court effected Roe v. Wade by using unconstitutional "iron curtain" procedures in a mock trial without truth.[1]

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1. A. Denial of Assistance of Counsel
Counsel did not especially represent the unborn in the U.S. District Court in Roe v. Wade. And the U.S. Supreme Court denied a request by an original party to allow counsel to especially represent the unborn and defend their right to life. Thus, counsel did not represent the unborn at any stage of the original proceedings.

B. Denial of Prior Notice
The District Court did not even look to see if the lives of the unborn were protected by the U.S. Constitution; this question was argued for the first time after Roe v. Wade reached the Supreme Court. And the Supreme Court gave the parties no prior notice of the constitutional standards, or the burdens of proof, or the evidence, which the Court used to infer that the lives of the unborn were not protected by the U.S. Constitution. The first time the parties had notice was when Roe v. Wade was published, and the victims were already condemned to death. An original party objected that it lacked the prior notice needed to defend the unborn.

C. Secret Evidentiary Proceedings
The Court used some secret evidentiary process, not open to the parties, to find

And the Court maintains its killings by using "iron curtain" procedures in mock trials without truth, despite continual objection that the Court was using criminal procedures to maintain its killings:

1. The Supreme Court willfully refuses to allow retained (no cost to taxpayers) counsel to represent the victims being

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evidence to infer that the lives of the unborn were not protected by the U.S. Constitution. An original party objected that the Court's facts were "unknown to the parties" and it never had opportunity to cross-examine the Court's evidence.

D. Denial of Right to Cross-Examine
An original party asked permission to cross-examine the evidence which the Court used to infer that the lives of the unborn were not protected by the Constitution. Since the Court found its evidence in secret proceedings, the parties had not previously seen the evidence. But the Supreme Court would not allow its evidence to be cross-examined.

E. Denial of Right to Present Evidence
An original party asked permission to present evidence under the new constitutional standards, which it had not seen before, to show that the lives of the unborn are protected by the Constitution. But the Court refused to allow it. And thus the killings commenced.

killed and defend their right to life.[2]

2. The Supreme Court willfully refuses to allow its evidence in Roe v. Wade, which it used to infer that "the word 'person'...

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2. Some of the cases are: Colautti v. Franklin, 439 U.S. 379, motion to allow counsel for the unborn denied 437 U.S. 902; Anders v. Floyd, 440 U.S. 445, motion to allow counsel for the unborn denied 439 U.S. 890; Bellotti v. Baird, 443 U.S. 622, motion to allow counsel for the unborn denied 439 U.S. 1065; Ashcroft v. Freiman, affirmed 440 U.S. 941, motion to allow counsel for the unborn denied, 440 U.S. 941; United States v. Zbaraz, 448 U.S. 358, motion to allow counsel for the unborn denied 444 U.S. 1030; Harris v. McRae, 448 U.S. 297, motion to allow counsel for the unborn denied 445 U.S. 941; H.L. v. Matheson, 450 U.S. 398, motion to allow counsel for the unborn denied 445 U.S. 959; Simopoulos v. Virginia, 462 U.S. 506, motion to allow counsel for the unborn denied 458 U.S. 1104; Planned Parenthood of Kansas City v. Ashcroft, 462 U.S. 476, motion to allow counsel to for the unborn denied 458 U.S. 1104; Akron Center for Reproductive Health v. Akron, 462 U.S. 416, motion to allow counsel to for the unborn denied 458 U.S. 1104; Diamond v. Charles, 476 U.S. 54, motion to allow counsel for the unborn denied 473 U.S. 932; Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747, motion to allow counsel for the unborn denied 473 U.S. 931; Hartigan v. Zbaraz, 98 L Ed 2d 478 (1988), motion to allow counsel for the unborn denied 479 U.S. 1003.

does not include the unborn," to be confronted and cross-examined.[3]

3. The Supreme Court willfully refuses to allow evidence to be presented to show that the Constitution's unalienable guarantee of life to "any person" includes the unborn.[4]

These are basically the procedures cited by the Nuremberg Court as part of the evidence to convict the Nazi judges of complicity in extermination and murder.[5]

The Supreme Court's own rulings on due process of law show these procedures to be

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3. See cases, supra note 2.

4. See cases, supra note 2.

5. "The trials ... did not approach even a semblance of ... justice. The accused ... were denied the right to introduce evidence, to be confronted by witnesses against them.... They were ... denied the right of counsel of their own choice.... (P)roceedings ... were secret." United States v. Altstoetter, supra, at 1046-47 (1951). "Such a mock trial is not a judicial proceeding but a murder." Id., at 1164. "The prostitution of a judicial system for the accomplishment of criminal ends involves an element of evil to the State which is not found in frank atrocities which do not sully judicial robes." Id., at 1086.

unconstitutional,[6] and the willful use of these procedures to be criminal.[7]

If the Court had used these procedures to decree it "liberty" to kill Jews, it

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6. Even in civil proceedings (such as where loss of welfare is threatened) due process guarantees (1) prior notice of the factual and legal bases; (2) the right to assistance of counsel; (3) the right to cross-examine adverse evidence; and (4) the right to present evidence. Goldberg v. Kelly, 397 U.S. 254, 268-271 (1970). See also, In Re Gault, 387 U.S. 1 (1967).

Could it be possible that procedures, which could not be used to deprive a mother of welfare, could be used to exclude her from the protection of the U.S.Constitution so that she could be killed with impunity from criminal laws? This is preposterous.

The Constitution would not permit any court to condemn even one single Jew to death in a criminal case, but deny any of these procedural rights. Then neither can it permit any court to condemn all Jews in the United States to death, but deny any of these procedural rights, by calling it a civil proceeding, and decreeing the lives of all Jews are not protected by the U.S. Constitution, and it is "liberty" to kill all Jews with impunity from criminal laws.

Any victim is entitled to all the procedural protections before any court can decree that the victim's life is not protected by the Constitution, and the victim can be killed with impunity from criminal statutes.

7. "Even judges ... could be punished criminally for willful deprivations of constitutional rights." Imbler v. Pachtman, 424 U.S. 409 (1976).

would be condemned as murder. Judges may have more sympathy for other victims, but changing the names of the victims will not change the legal result.

The Court maintains its decree "MASS MURDER IS LIBERTY" by refusing to allow truth to work in its Court. No truth seeking process was left unbloodied. It is notorious that truth is not permitted to work in this Court, and that the Court falsifies history to achieve its ends.[8]

The record proves the Court used "iron curtain" procedures, a mock trial without

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8. "The Court ... has flouted the will of the framers and substituted an interpretation in flat contradiction of the original design.... Such conduct impels one to conclude that the Justices are become a law unto themselves.... It perilously resembles ... Hitlerism." R. Berger, Government by Judiciary: The Transformation of the Fourteenth Amendment 408-12 (1977).

"Court had adjourned in the real world and reconvened in Cloud Cuckooland. [The Justices] began to invent a country suited to their purposes.... They have falsified the American past ... and no one in charge seems prepared to do anything about it." T. Landers, To A Traditionalist, Mr. Ron Sounds So Good, Wall St. J., edit. page, Dec. 27, 1984.

truth, to do the most forbidden thing, to defy the guarantee of life to "any person" so millions of victims could be killed with impunity from criminal statutes; and the Court maintained its killings for fifteen years by using "iron curtain" procedures in mock trials without truth. In the words of the Nuremberg court, "Such a mock trial is not a judicial proceeding but a murder."

These procedures are still another "murder gun" precedent which this Court holds to the head of every American; everyone is now a hostage of this Court; judges can use this "iron curtain" process to destroy anyone. The process makes Roe v. Wade void.[9]

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9. A more detailed description of the procedures is made in the MOTION TO ALLOW COUNSEL REPRESENT CHILDREN UNBORN AND BORN ALIVE, filed in this case, and incorporated by reference.

DUE PROCESS OF LAW HAS COMPELLED THE U.S. SUPREME COURT TO CONFESS IN COURT THAT IT IS GUILTY OF MASS MURDER, AND TO ADMIT THAT THE UNALIENABLE GUARANTEE OF LIFE TO "ANY PERSON" DOES INCLUDE THE UNBORN.

For the 101st time, the U.S. Supreme Court is accused of criminally defying the guarantee of life to "any person" and exterminating millions of victims whom the U.S. Constitution endeavors to preserve.

For the 77th time, the U.S. Supreme Court is accused of mass murder in violation of state and federal statutes.

For the 81st time, this Court is accused of using criminal procedures to effect and maintain Roe v. Wade killings.

John Marshall would have called Roe v. Wade "treason to the Constitution."[1]

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1. Chief Justice Marshall wrote that this Court could not extend the Constitution "to objects not...contemplated by its framers." Ogden v. Saunders, 12 Wheat. at 332. If the Court usurped such power, it would be "treason to the Constitution." Cohens v. Virginia, 6 Wheat. at 404. By decreeing "liberty" to be the very thing which the framers had condemned to be "murder," the Court has indisputably extended the Constitution to objects not contemplated by its framers. For 15 years, "treason to the

But, for fifteen years, the U.S. Supreme Court has never denied the charges, much less attempted to prove the charges to be false. These facts are unparalleled in the legal history of the world.

Under this Court's own rulings, its silence year after year, while the victims

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Constitution" has masqueraded as "the supreme law of the land."

The Court supplanted the Constitution as the supreme law. Chief Justice Marshall wrote that "the Constitution derives its whole authority" from the consent of the governed. McCulloch v. Maryland, 4 Wheat. at 403. Yet, the Court now defies this consent; it simply invents a dream world and imposes it on the people by decree. A divided Congress is unable to control this Court, which results in rule by minority.

Thomas Jefferson warned that this Court was "the most dangerous" branch because judges were "installed for life, responsible to no authority (for impeachment is not even a scarecrow)"; and judges twist words to make "anything mean everything or nothing, at pleasure" with judges finally becoming "despots." Thus Roe v. Wade fully explained.

People have lost faith in the simple power of facts to prove: falsehood is called truth; murder is called liberty; treason is called law. This defeat of the consent of the governed as the basis of law is the most momentous revolution in human history. The way out was shown by Abraham Lincoln, who would "call things by their right names, no matter who was offended."

are being killed, is an admission that the charges are true.[2] In the Court's words:

> "Failure to contest an assertion, however, is considered evidence of acquiescence only if it would have been natural under the circumstances to object to the assertion in question." United States v. Hale, 422 U.S. 171, 176 (1975).

The circumstances leave no doubt that due process has compelled the U.S. Supreme Court to confess that the charges are true.

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2. Under the tacit confession rule, failure to deny a charge is admissible as a confession that the charge is true. 4 Wigmore, Evidence, § 1071-1072 (Chadborn rev. 1972). "Underlying the rule is the assumption that human nature prompts an innocent man to deny false accusations and consequently a failure to deny a particular accusation tends to prove belief in the truth of the accusation." McCormick on Evidence, § 161 (1972). The Court has often affirmed this rule. "(T)he Court has consistently recognized that ... silence in the face of accusation is a relevant fact.... Silence is often evidence of the most persuasive character." Baxter v. Palmigiano, 425 U.S. 308, 319 (1976). And the rule is ancient. As Socrates cross-examined at his trial 2400 years ago: "(Y)ou are silent, and have nothing to say. But is not this rather disgraceful, and a very considerable proof of what I was saying?" "I may assume that your silence gives consent." Plato 41, 45 (Jowett tr. 1942).

First, the evidence makes it as clear as daylight why the Court is silent in the face of the charges: the charges are proved to be true.[3] Truth cannot be proved false.

Second, the charges were made in cases filed pursuant to the Constitution and laws of the United States. Chief Justice John Marshall ruled that judges who "close their eyes on the Constitution" and "condemn to death those victims whom the Constitution endeavors to preserve" commit "crime."[4]

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3. The Court decreed killings to be "liberty" which States had defined to be "murder." This is mere historical fact; no denial is possible. As John Marshall said, "a fact which has existed cannot be made never to have existed." Marbury v. Madison, 1 Cranch at 167 (1803).

4. Marbury v. Madison, 1 Cranch 137, 179-180 (1803). This correctly states the criminal law. Where there is an affirmative duty to act, the deliberate omission to do that duty, which results in death to others, can be prosecuted as homicide. Perkins, Criminal Law 604 (2nd ed. 1969).

The only Nazi to plea guilty at Nuremberg cited this law. When warned of Auschwitz, Speer wrote: "I did not investigate - for I did not want to know what was happening there.... From fear of discovering something which might have made me turn from my course, I closed my eyes." A. Speer, Inside the Third Reich 375-76

The Court had a legal duty to fully hear allegations that Roe v. Wade was wrongly decided. The Court affirmed its duty:

> "(I)ts opinion upon the construction of the Constitution is always open to discussion when it is supposed to have been founded in error, and that its judicial authority should hereafter depend altogether on the force of the reasoning by which it is supported." The Passenger Cases, 7 How. 282, 470 (1849).

Third, the Court's steadfast silence for fifteen years in the face of the scores of accusations is unparalleled in the legal history of the world; the Court cited this very circumstance as making confession by silence more trustworthy.

> "Silence gains more probative weight where it persists in the face of accusation, since it is assumed in such circumstances that the accused would be more likely than not to dispute an untrue accusation." United States v. Hale, 422 U.S. 171, 176 (1975).

Fourth, not only has the Court's silence persisted in the face of repeated accusations, but it has persisted even in

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(1970). This "deliberate blindness" is complicity in criminal extermination.

the teeth of warnings that its silence was being taken as an admission that the charges are true.

Fifth, the charges described judicial crimes not surpassed in all history, that (1) judges had done the most forbidden thing, and defied the unalienable guarantee of life to "any person," the two most important words ever written into law, and criminally exterminated millions of children; (2) the United States was being ruled by the most corrupt decree which the human mind could even imagine: "MASS MURDER IS LIBERTY"; (3) due process of law had compelled the judges to confess to guilt of mass murder; and (4) the judges schemed to reaffirm the legitimacy of their murders in mock trials designed to keep truth from working in all state and federal courts.[5]

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5. In Akron v. Akron Center for Reproductive Health, 462 U.S. 416 (1983), the Court reaffirmed Roe v. Wade by stare decisis in a mock trial without truth.

The parties did not ask the Court to overrule Roe v. Wade. This was done by the amicus curiae brief by the Legal Defense

The United States being ruled by the decree "MASS MURDER IS LIBERTY" is the most catastrophic crime in the history of civilization; it smashes the hopes of the whole human race for a government of laws, and

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Fund for Unborn Children, as follows: "For the 52nd time, the U.S. Supreme Court is accused in its own court with mass murder." The amicus brief laid out the evidence, and concluded: "THE U.S. SUPREME COURT HAS CONFESSED IN COURT TO GUILT OF CRIMINAL EXTERMINATION, INCLUDING MASS MURDER, AND THIS IS THE LEGAL EQUIVALENT OF THE EXPRESS OVERRULING OF ROE v. WADE." But this Court responded to these arguments by saying:

> And arguments continue to be made, in these cases as well, that we erred in interpreting the Constitution. Nonetheless, the doctrine of stare decisis, while perhaps never entirely persuasive on a constitutional question, is a doctrine that demands respect in a society governed by the rule of law. We respect it today, and reaffirm Roe v. Wade.

Thus, the Court's response to "arguments" that it was guilty of mass murder. When a court rules that its decree "MASS MURDER IS LIBERTY" must be obeyed without a hearing or even a question, then history could not reveal a more murderous mockery of "the rule of law." The Court hid behind stare decisis in a mock trial and used this ruse of law to defraud all lower courts into obeying Roe v. Wade without question.

reduces government to the matter of which murderer can grab power and be obeyed.

Never in the legal history of the world was it more imperative to deny charges if they were untrue. Judges, under solemn legal duty to uphold the law, are accused of mass murder. The evidence is laid out in court. The judges have done the most forbidden thing, and defied the guarantee of life. Little children are being killed. The killings violate criminal statutes. Pictures of the dead are shown to the judges. But for 15 years the judges do not meet the evidence; do not prove it false.

A government of laws can permit only one conclusion to be drawn from these facts: The U.S. Supreme Court was met in court with the truth; truth worked in the only manner in which it was permitted to work; and due process of law compelled this Court to admit, in the most emphatic manner which the mind can imagine, that the words "any person" do include the unborn.

Any judge who closes his eyes on these facts, and chooses to take part in a national scheme to kill little children, in defiance of the guarantee of life to "any person," and criminal statutes, to maintain the decree "MASS MURDER IS LIBERTY," knows he is guilty of complicity in mass murder and criminal defiance of the Constitution.[6]

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6. Roe v. Wade asserted to legalize killings which statutes had made criminal. Since Roe v. Wade is a mistake of law, all the killings since 1973 can be prosecuted.

The ex post facto provisions of the U.S. Constitution do not apply to judicial decisions which are a mistake of law. Ross v. Oregon, 227 U.S. 150, 161 (1912).

The general rule is that mistake of law is no excuse for breaking the law. R. Perkins, Criminal Law 920 (2d ed. 1969).

The limited affirmative defense of reasonable reliance on an official judicial opinion, thereafter determined to be a mistake of law, does not apply to homicide cases. Model Penal Code, Tentative Draft No. 4, Comments Sec. 2.04, page 138; R. Perkins, Criminal Law 928 (2d ed. 1969).

Thus, the law applied at Nuremberg applies to this case. Obedience to the orders of judicial superiors is no excuse for complicity in murder. United States v. Altstoetter, supra, at 983-985.

Perhaps judges responsible for the Roe v. Wade murders did not believe they were breaking the law. But as Oliver Wendell Holmes wrote: "Ignorance of the law is no excuse for breaking it.... It is no doubt true that there are many cases in which the

In explaining how the Nazi regime got away with its monstrous crimes, Winston Churchill quoted Machiavelli: "Men avenge slight injuries, but not grave ones." The Court knows that truth well; the legal foundation of the United States now rests on the assumption that the gravest crime in history cannot be avenged.

The photo on the last page shows a second stage abortion under Roe v. Wade. If the child were born alive, this Court would be guilty of murder. If the child were born

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criminal could not have known that he was breaking the law, but ... the lawmaker has determined to make men know and obey." O.W. Holmes, The Common Law 41 (1963).

Even if the Supreme Court held a gun to the head of a lower judge, and threatened death unless he obeyed Roe v. Wade, it would not be a defense to murder, for "he ought rather to die himself than escape by the murder of an innocent." 4 Bl. Com. 30.

The law makes a mortal distinction between killing and not killing: (1) any judge who stopped the Roe v. Wade killings, and made a mistake of law, could only be overruled on appeal; (2) but any judge who allows the killings to continue and makes a mistake of law, can be convicted of murder, and be sentenced to death. The law of capital murder is a hard school, where lessons are taught only one time, and mistakes of law are not forgiven.

dead, this Court would be guilty of extermination under 18 U.S.C. § 242.

Truth has worked in this Court; judges cannot stop it. Due process has compelled this Court to admit that the unalienable guarantee of life to "any person" does include the unborn.

CONCLUSION

Merely overruling Roe v. Wade will simply continue its crimes, perhaps on a less extensive scale. The Court misguided this nation and the entire world.

Now the Court must promulgate the truth, that the universal and unalienable guarantee of life to "any person," made in the Fifth and Fourteenth Amendments of the U.S. Constitution, do include the unborn, and States have a duty to protect unborn life.

Alan Ernest
Counsel

AMICUS CURIAE

BRIEF

Supreme Court, U.S.
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No. 88-790

In The Supreme Court of the United States

OCTOBER TERM, 1989

BERNARD TURNOCK

v.

RICHARD M. RAGSDALE

ON APPEAL FROM THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR LARRY JOYCE AS AMICUS CURIAE IN SUPPORT OF APPELLANTS

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TABLE OF CONTENTS

	Page
Interest of Larry Joyce	1
Summary of Argument	1
Argument:	
I. THERE IS A COMPELLING NEED IN THE CASE AT BAR TO REVIEW THE ISSUE OF PRENATAL PERSONHOOD *DE NOVO*	3
A. There Was No Case Or Controversy In *Roe v. Wade* Concerning The Specific Issue Of Prenatal Personhood	3
B. There Is A Compelling Need, Based On *Martin v. Wilks*, To Review This Issue *De Novo*	15
C. Any Possible Objection To The Raising Of This Issue At This Stage Of The Proceedings Is Answered By *Hoe v. Wilson* and*Provident Tradesmen's Bank And Trust Co. v. Patterson*	15
D. A Decision By This Court Not To Reconsider This Issue Now Will Increase The Potential For Greater Upheaval In the Law Later On	16
II. NEITHER THE OPINIONS OF JUSTICES REHNQUIST, WHITE, OR SCALIA, NOR THE LANGUAGE OR HISTORY OF THE FOURTEENTH AMENDMENT, PRECLUDE THE APPLICATION OF THE EQUAL PROTECTION CLAUSE TO PRENATAL HUMANS	19
A. Even Opinions Of This Court--Much Less Opinions of Individual Justices---Do Not Constitute Precedents For Points Decided *Sub Silencio*	19

B. The Jurisprudence Of Original Intent Must Not Be Confused With The Jurisprudence of Original Result 20

1. A Recognition Of Prenatal Personhood Produces the Same Result In Contemplation Of Law Today As Would Have Been Achieved In 1868, Even Though The Result In Fact Would Be Quite Different 23

a. A finding of prenatal personhood would not overrule the basic premise of *Roe* 25

Conclusion 28

TABLE OF AUTHORITIES

Cases:

Akron v. Akron Center For Reproductive Health, 462 U.S. at 458 (1983) (O'Connor, J., dissenting) 1

California v. Arizona, 440 U.S. 59 (1979) 16

Craig v. Boren, 429 U.S. 190 (1976) 14

Doe v. Bolton, 413 U.S. 179 (1973 9

Doe v. Bolton, 413 U.S. 223 (1973) (Rehnquist, J., dissenting) 19

Edelman v. Jordan, 415 U.S. 651 (1974) 20

Eisenstadt v. Baird, 405 U.S. 438 (1972) 8

Flast v. Cohen, 392 U.S. 83 (1968) 14

Flora v. United States, 362 U.S 145 (1960) 26

GTE Sylvania, Inc. v. Consumers Union of the United States, Inc., 445 U.S. 375 (1980) 14

Hoe v. Wilson, 76 U.S. (9 Wall.) 501 (1869) 2,15, 16

Horn v. Lockhart, 84 U.S. (17 Wall.) 570 (1873) 16

Kendig v. Dean, 97 U.S. (7 Otto) 423 (1876) 16

Lumbermen's Mutual Casualty Co. v. Elbert, 348 U.S. 48 (1954) 16

Mallow v. Hinde, 25 U.S. (12 Wheat) 193 (1827) 16

Martin v. Wilks, ___ U.S. ___, #87-1614, Slip opinion (decided June 12, 1989) 2,15

Mechanics Bank v. Seton, 26 U.S. (1 Pet.) 299 (1828) 16

Nathanson v. Labor Board, 344 U.S. 23 (1952) 15

Niles-Bement Co. v. Iron Moulders Union, 254 U.S. 77 (1920) 16

Ollman v. Evans, 750 F.2d at 995 (1984) (Bork, J., concurring) 20, 21, 22

Provident Tradesmen's Bank And Trust Co. v. Patterson, 390 U.S. 102 (1968) 2, 15, 16

Railroad Co. v. Orr, 85 U.S. (18 Wall.) 471 (1873) 16

Ribon v. Railroad Companies, 83 U.S. (16 Wall.) 446 (1872) 16

Roe v. Wade, 410 U.S. 113 (1973) ..... *passim*

Roe v. Wade, 410 U.S. at 171 (1973) (Rehnquist, J., dissenting) 19

Roe v. Wade, 410 U.S. at 221 (1973) (White, J., dissenting) 19

Secretary of Maryland v. Jos. H. Munson Co., 467 U.S. 947 (1984) 8

Shields v. Barrow, 58 U.S. (17 How.) 130 (1854) 16

Simon v. Eastern Kentucky Welfare Rights Organization, 426 U.S. 26 (1976) 9, 14

Swan Land And Cattle Co. v. Frank, 148 U.S. 603 (1893) 16

United Shoe Machinery Co. v. United States, 258 U.S. 451 (1922) 16

Webster v. Fall, 266 U.S. 507 (1925) 20

Webster v. Reproductive Health Services, #88-605, Slip opinion (decided July 3, 1989) ..... *passim*

Webster v. Reproductive Health Services, #88-605, Slip opinion (decided July 3, 1989) Scalia, J., concurring in part and concurring in the judgment) 19

Webster v. Reproductive Health Services, #88-605, Slip opinion (decided July 3, 1989) (Blackmun, J., concurring in part and dissenting in part) 1, 25

Webster v. Reproductive Health Services, #88-605, Slip opinion (decided July 3, 1989) (Stevens, J., concurring in part and dissenting part) 1, 19, 23

Miscellaneous:

Brief of appelle Henry Wade in *Roe v. Wade*, #70-18, 410 U.S. 113 (1973) 5

Brief of Larry Joyce as *amicus curiae* in *Webster v. Reproductive Health Services*, #88-605, Slip opinion (decided July 3, 1989) 1

Nomination of Robert H. Bork to be Associate Justice of the Supreme Court of the United States: Hearings before the Committee on the Judiciary, United States Senate, 100th Cong. 1st Sess., S. Hrg. 100-1011, Serial No. J-100-64, Part 1, pp. 285-286 ..... 22, 23

Tr. of Oral Arg. before three-judge district court in *Roe v. Wade*, #70-18, 410 U.S. 113 (1973) (as per U.S. Supreme Court filing, July 30, 1970) 6

Tr. of Oral Arg. and Rearg. in *Roe v. Wade*, #70-18, 410 U.S. 113 (1973) and *Doe v. Bolton*, #70-40, 410 U.S. 179 (1973) (consolidated cases) (Hoover Reporting Co.) 4, 5, 6, 7, 11, 13, 18

Pet. for Reh. in *Roe v. Wade*, #70-18, 410 U.S. 113 (1973) 5, 9, 13

Pet. for Reh. in *Doe v. Bolton* #70-40, 410 U.S. 179 (1973) 12, 13

INTEREST OF LARRY JOYCE

The *amicus* is a pharmacist and an attorney who completed six units of independent study on *Roe v. Wade* while in law school and who was an *amicus* in *Webster v. Reproductive Health Services.*[1]

SUMMARY OF ARGUMENTS

There is a compelling need in the case at bar to review the issue of prenatal personhood *de novo*. There was no case or controversy in *Roe v. Wade* on the specific issue of prenatal personhood within the meaning of the Fourteenth Amendment. The interests of the State of Texas, like those of Jane Roe, were materially adverse to a finding of such personhood. Texas did state that it was seeking a recognition of prenatal personhood under the Fourteenth Amendment, but from the time of oral argument before the three-judge panel in the district court to the petition for a rehearing before this Court, Texas made it clear that it was seeking a status of personhood for prenatal life which the state could define and create. Thus, prenatal humans would have no rights against the state unless Texas chose to create such rights. This is not personhood within the meaning of the Fourteenth Amendment, in which

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[1] That brief discussed three point which were of particular concern to Justices Blackmun and Stevens in their opinions in *Webster*, #88-605 (decided July 3, 1989). First, embryo transfer technology places the meaning of live birth (and viability) in question, and effectively places *Roe v. Wade* on even more of a collision course with itself today that it was when *Akron v. Akron Center For Reproductive Health* was decided. (See 462 U.S. at 458 (1983) (O'Connor, J., dissenting)). Brief of this *amicus* in *Webster* at p.28.

Second, the Establishment Clause does not prevent us from recognizing prenatal personhood. Rather, precisely the opposite is true; it requires us to recognize such personhood. Brief in *Webster* at p 15.

Third, protection of prenatal human life does not carry with it, per se, the authority to prohibit birth control agents which work after conception. Brief in *Webster* at p. 29.

Three copies of the brief of this amicus in *Webster* have been submitted, along with the required copies of this brief, to counsel for appellee Ragsdale in the case at bar.

one has inherent rights against the state. Consequently, since neither Texas nor Roe were seeking true Fourteenth Amendment personhood for prenatal humans, there was no case or controversy in *Roe* on this specific issue.

Further, since the interests of Texas were adverse to a recognition of true Fourteenth Amendment personhood for prenatal humans, Texas did not even have standing to assert such personhood.

This Court has recognized that it has no authority to proceed to judgment on a point concerning which there is no case or controversy. *Roe* itself should have been remanded to the district court for the appointment of a guardian for those prenatal humans who could be affected by the outcome of the litigation.

Reconsidering the issue of prenatal personhood *de novo* and ruling the opposite way does not even constitute an instance of overruling precedent in the ordinary sense, for there has never even been a bona fide holding on that point, supported by the case or controversy requirement, for this Court to overrule to begin with.

Under the holding of *Martin v. Wilks*, there is a compelling need to review this issue in the instant case, for no person shall be deprived of life, liberty, or property in a case in which such person is not a party to the proceedings.

Any possible objection to the raising of this issue at this stage of the proceedings is answered by *Hoe v. Wilson* and *Provident Trademen's Bank And Trust Co. v. Patterson.* This Court has recognized that appellate courts must act *sua sponte* to defend the rights of nonjoined indispensable parties.

Time alone will not heal the jurisdictional defect of *Roe*. The defect will always remain there, waiting for the day when it shall be brought up again. By then a recognition of this error and a reversal of it could upset volumes of supposedly settled law.

Neither the opinions of Justices Rehnquist, White, or Scalia, nor the language or history of the Fourteenth Amendment, preclude the application of the Equal Protection Clause to prenatal humans. Even opinions of this Court---much less opinions of individual justices---do not constitute precedents for points decided *sub silencio*.

Those who claim that the jurisprudence of original intent would preclude a recognition of prenatal personhood mistakenly think that original intent means original result in fact instead of original result in law.

I. THERE IS A COMPELLING NEED IN THE CASE AT BAR TO REVIEW THE ISSUE OF PRENATAL PERSONHOOD *DE NOVO*.

A. There Was No Case Or Controversy In *Roe v. Wade* Concerning The Specific Issue Of Prenatal Personhood.

Prior to this Court's actual holding in *Roe*[2] that there is a constitutional right to an abortion, the interests of the State of Texas (i.e. Texas and Wade), like those of Jane Roe, were materially adverse to this Court's recognition of prenatal personhood. As this Court said in *Roe*,

> "When Texas urges that a fetus is entitled to Fourteenth Amendment protection as a person, it faces a dilemma. Neither in Texas nor in any other State are all abortions prohibited. Despite broad proscription, an exception always exists. The exception contained in Art. 1196, for an abortion procured or attempted by medical advice for the purpose of saving the life of the mother, is typical. But if the fetus is a person who is not to be deprived of life without due process of law, and if the mother's condition is the sole determinant, does not the

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[2] 410 U.S. 113 (1973).

Texas exception appear to be out of line with the Amendment's command?

"There are other inconsistencies between Fourteenth Amendment status and the typical abortion statute. It has already been pointed out, n. 49, *supra*, that in Texas the woman is not a principal or an accomplice with respect to an abortion upon her. If the fetus is a person, why is the woman not a principal or an accomplice? Further, the penalty for criminal abortion specified by Art. 1195 is significantly less than the maximum penalty for murder prescribed by Art. 1257 of the Texas Penal Code. If the fetus is a person, may the penalties be different?"[3]

And at oral reargument, the following exchange took place.

Question: Well, if you're correct that the fetus is a person, then I don't suppose you'd have---the State would have great trouble permitting an abortion, would it?

Mr. Flowers: Yes, sir.

Question: In any circumstance?

Mr. Flowers: It would, yes, sir.[4]

The State of Texas was caught between a rock and a hard place. On the one hand it wanted to win its case; on the other hand it did not want its statute to become constitutionally suspect in later cases.

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[3] 410 U.S. at 157, n. 54.

[4] Tr. of Oral Rearg. 60-61. (Note: This is the transcript of the Hoover Reporting Company, which identifies itself as the official reporters of the oral arguments, and which states that a true copy of such transcript is filed with the Court. Page numbers based on other reports of the oral arguments may be different. The oral arguments and reargruments of *Roe* and the companion case, *Doe v. Bolton*, are numbered as being all part of one series.)

So Texas tried to have it both ways. On the one hand it would state that it was seeking a recognition of personhood under the Fourteenth Amendment;[5] but from the time of oral argument before the three-judge panel in the district court to the petition for a rehearing before this Court, Texas made it clear that it was seeking a status of personhood for prenatal life which the state could define and create. Thus, prenatal humans would have no rights against the state unless Texas chose to create such rights. This is not true personhood within the meaning of the Fourteenth Amendment, in which one has inherent rights against the state. The relevant excerpts from the record illustrate the point.

Mr. Flowers: Perhaps (a determination of personhood) would be better left to that legislature...

Question: Well, if you're right that an unborn fetus is a person, then you can't leave it to the Legislature to play fast and loose dealing with that person. In other words, if you're correct in your basic submission that an unborn fetus is a person, then abortion laws such as that which New York has are grossly unconstitutional, isn't it?

Mr. Flowers: That's right, yes.

Question: Allowing the killing of people.

Mr. Flowers: Yes, sir.

Question: A person.

Mr. Flowers: Your Honor, in Massachusetts, I might point out---

Question: Definitely it isn't up to the Legislature; it's a Constitutional problem, isn't it?

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[5] Brief of appellee at 31 and 56, Tr. of Oral Rearg. (numerous references), and Pet. for Reh. 6 and 8.

Mr. Flowers: Well, if there would be any exceptions within this---

Question: The basic constitutional question, initially, is whether or not an unborn fetus is a person, isn't it?

Mr. Flowers: Yes, sir. And entitled to the constitutional protection.

Question: And that's critical to this case, it is not?

Mr Flowers: Yes, sir, it is.[6]

Texas had recognized from the beginning that its interests would be upheld by a legislative finding of prenatal personhood instead of by a recognition of true personhood within the meaning of the Fourteenth Amendment.

Mr. Tolle: (The State's right to protect life) becomes, I think, for the purpose of public order, a legislative problem as to when they're going to set up an arbitrary time (to protect such life).[7]

Other excerpts, again from the oral reargument of the case, also illustrate the point.

Mr. Flowers: ...But it is the position of the State of Texas that upon conception we have a human being, a person within the concept of the Constitution of the United States and that of Texas, also.

Question: Now, how should that question be decided, is it a legal question, a constitutional question, a medical question, a philosophical question, or a religious question, or what is it?

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[6] Tr. of Oral Rearg. 66-67. (Hoover Reporting Co.)

[7] Tr. of Oral Arg. before the three-judge district court panel 106. (Page number as per filing with the U.S. Supreme Court, July 30, 1970.)

Mr. Flowers: Your Honor, we feel that it could be best decided by a Legislature in view of the fact that they can bring before it the medical testimony, the actual people who do the research.[8]

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Mr. Flowers: Gentlemen, we feel that the concept of a fetus being within the concept of a person, within the framework of the United States Constitution and the Texas Constitution is an extremely fundamental thing.

Question: Of course, if you're right about that, you can sit down, you've won your case.

Mr. Flowers: Your Honor,---

Question: Except insofar as maybe the Texas abortion law presently goes too far in allowing abortions.

Mr. Flowers: Yes, sir. That's exactly right.[9]

The arguments of the State of Texas did take on the form of seeking recognition of prenatal personhood within the meaning of the Fourteenth Amendment.[10] But the substance of these arguments was that Texas wanted to retain the right to determine who is and who is not a person. Every reference to prenatal personhood is qualified, shortly before or after such reference, to an asserted right of Texas to define personhood by legislation. Thus, the interests of Jane Roe and the State of Texas were in substance the same on this specific, limited point. Both wanted the same thing; for neither wanted recognition of prenatal personhood with inherent rights *viz a viz* anyone else or the state.

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[8] Tr. of Oral Rearg. 59. (Hoover Reporting Co.)

[9] Tr. of Oral. Rearg. 62. (Hoover Reporting Co.)

[10] See note 5, *supra*.

This is not to suggest or imply that there was no case or controversy on the question of whether Jane Roe had a right *viz a viz* the State of Texas to terminate her pregnancy. The adversarial clash of interests there was obvious. But the question of whether Jane Roe had a right *viz a viz* the State of Texas to terminate her pregnancy is not the same question of whether she had the right *viz a viz* her prenatal daughter to terminate her life in the process, and it certainly is not the same question of whether that prenatal daughter had all the rights inherent in personhood *viz a viz* the State of Texas.

Texas was in a position to seek a recognition of true prenatal personhood under the Fourteenth Amendment when it filed its petition for a rehearing. For by then this Court had already declared that there is a constitutional right to an abortion. The position of the State of Texas was thereby materially altered from one of being adverse to this Court's recognition of true prenatal personhood to one of being in favor of such recognition.

For a recognition of such personhood would be the only way that Texas could salvage what it could from the case. And such recognition would leave at least most of the applications of the Texas abortion statute free from a cloud of doubt as to their constitutionality.

Thus, the true adversarial clash between the parties on this point was developed by then to form a true case or controversy on the question of prenatal personhood. But prior to that time Texas's interest in this Court's recognition of prenatal personhood was only speculative, being dependent upon a rejection of its true interest, which was the right to define by legislation as it pleased what is and what is not a person. And thus, prior to its filing of a petition for a rehearing, the State of Texas lacked standing to assert the true Fourteenth Amendment personhood of prenatal humans.[11]

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[11] *Secretary of Maryland v. Jos. H. Munson Co.*, 467 U.S. 947 (1984) (standing is limited to those who can be expected to frame the issues and present them with the necessary adversarial zeal), *Eisenstadt v. Baird*, 405

Standing, of course, is part of the case or controversy requirement of federal judicial jurisdiction. *Simon v. Eastern Kentucky Welfare Rights Organization*, 426 U.S. 26 (1976).

Perhaps Texas did seek true personhood within the meaning of the Fourteenth Amendment in its petition for a rehearing. Texas did argue at one point therein that a prenatal human is a person "within the meaning of the Constitution and its Amendments, and is entitled to be protected *equally* with the life and health of the mother" (emphasis in original),[12] and in the closing paragraph of the petition it asked this Court to squarely hold that the Equal Protection Clause is applicable to prenatal humans.[13] But even this must be read in light of the fact that in between these two statements the State of Texas made it clear that what it really wanted was the right to create and define by legislation the personhood of prenatal humans, and it noted that, in its words, certain courts have "rightfully" held that this is so.[14]

Perhaps Texas was uncertain as to what it should ask for. But in any case, it recognized throughout the litigation that a recognition of true prenatal personhood would make its statute constitutionally suspect, and that it should seek the right to define personhood by legislation.

The arguments of Texas in *Roe* parallel those of Bolton in the companion case, as the following excerpts from *Doe v. Bolton* [15] reveal.

Question: I'm a little confused. You say that the State is interested in protecting the life of the fetus, and yet the State statute under certain conditions, allows the death of the fetus.

U.S. 438 (1972) (the question of whether one has standing depends more on the effect of the litigation on the third party whose rights are being asserted than it does on the nature of the litigant *viz a viz* that third party).

[12] Pet. for Reh. 6.

[13] Pet. for Reh. 8.

[14] Pet. for Reh. 6-8.

[15] 410 U.S. 179 (1973).

Mrs. Beasley: That's right. There is a balancing of the interests, which we have talked about so much. Under the— Mary Doe suggests that she has a right, which emanates from–

Question: Is there any other statute in Georgia that says that (a) commission of three people can decide whether a man lives or dies?

Mrs. Beasley: Not a commission of three people.

Question: Well, is there any statute which says three doctors can decide whether a man lives or dies? Obviously—

Mrs. Beasley: Excuse me, not as to whether he lives or dies. But there is—

Question: —there is no such statute. But you can say, three doctors can decide as to whether what you claim is a living fetus, with the exact same rights as a grown person, can be killed.

Mrs. Beasley: No, I'm not saying that. I'm not saying that. What I am saying is this: under our Constitution, obviously, as Mr. Justice Stewart said, a person that's born has all the protections that the Constitution has to offer. But there is a gray area where we don't know when life, as such, begins, or humanity, or personhood, or any other term by which you want to call it. Obviously life occurs before birth, because there's movement, and medicine recognizes that.

So let's not talk about life then, let's just say personhood, which of course is not a medical term at all.

Question: Well, what is a fetus?

Mrs. Beasley: There's a gray area, and that is the arena in which we say the State has a right to determine, by its

Legislature, how far it will go in protecting that, because it's a matter of public policy.[16]

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The State, it is our position, has a right in this gray area, where we can't say the particular moment at which the State can protect human beings or say the particular moment at which the State can protect human beings or fetuses, or whatever area on the continuum of life that you want to talk about.

But there is a right, we think, that a living being has, which emanates from the Ninth Amendment itself. Because those rights are retained by the people, under the Ninth Amendment.[17]

****

...(I)t is a natural right under our order of things, emanating from the Ninth Amendment, to be let alone. And that, we say, is the right which the fetus has: the right to be let alone and not to be stopped in its growth or its birth at a time which would be premature.[18]

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Question: I take it you'd have no difficulty, from the position you've indicated, that you'd have no difficulty in sustaining a statute if the Legislature proscribed one set of standards for the first trimester or the first 140 days, and a more rigorous standard after that period?

Mrs. Beasley: That's right. I think it is a matter of degree, I think it's a value judgment that is best left in the hands of the Legislature to determine is this gray area of prior

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[16] Tr. of Oral Rearg. 86-87. (Hoover Reporting Co.)
[17] Tr. of Oral Rearg. 87. (Hoover Reporting Co.)
[18] Tr. of Oral Rearg. 89. (Hoover Reporting Co.)

to birth, what human rights there are prior to birth.[19]

****

If there's anything emanating from the Ninth Amendment, it's the fetus's right to be left alone, and his own self-preservation which is the ultimate responsibility of government to protect.[20]

Question: Are you saying that even if the fetus is not---whether the fetus is or is not a person under the Fourteenth Amendment, that there is a right of the fetus to be let alone, and it must be balanced with all the other factors involved?

Mrs. Beasley: Yes, indeed. I think there is that right. Plus other rights, or other interests which the State has, to see that it is let alone from undue destruction.[21]

And on petition for a rehearing, counsel for Bolton said,

> "The Constitution does not prohibit the State from exerting the power to protect rights retained by the people, that is, the right to determine for legal purposes what is a "person" insofar as the gray area of prenatal life is concerned. Nor does it prohibit the State from determining at what degree a living human entity may be protected on behalf of itself and of society."[22]

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> "The Court here made a value judgment which should be left to the people through their duly elected representatives or even, where they so choose, through

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19 Tr. of Oral Rearg. 91. (Hoover Reporting Co.)
20 Tr. of Oral Rearg. 92. (Hoover Reporting Co.)
21 Id.
22 Pet. for Reh. 4.

referendum."[23]

Thus, it is clear that the State of Georgia, like the State of Texas, recognized that its interest in the case was to seek a recognition of prenatal personhood which the state could define and create---i.e. a status other than true Fourteenth Amendment personhood. Specifically, Georgia was seeking a state-defined Ninth Amendment personhood status for prenatal humans.

Thus, since Bolton, like Doe, did not want a recognition of true Fourteenth Amendment personhood, there was no case or controversy in *Bolton* either over the specific, limited issue of prenatal personhood.

Counsel for Bolton did recognize this problem, and in the petition for a rehearing said,

> "The Court has recognized that fetal life is a continuum. Thus before a point is selected at which our government by judicial fiat must be blindfolded to its existence, the Court should have every benefit of a complete record and the representation by a guardian ad litem for that fetal entity and for its natural right to develop to birth. The presumption in this regard should be on the side of life so that its fullest defenses may be aired."[24]

This parallels what the State of Texas had said at the oral reargument of the case,

> "Who is speaking for these children? Where is the counsel for these unborn children, whose life is being taken? Where is the safeguard of the right to trial by jury?"[25]

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23 Pet. for Reh. 9.
24 Pet. for Reh. 5.
25 Tr. of Oral Rearg. 64. (Hoover Reporting Co.)

Those questions were never answered in *Roe* or *Doe*. They remain unanswered to this day. And unless that segment of humanity gets its full and fair opportunity to present its case to this Court, the holding by this Court that such humans are not persons will remain based on cases in which no party really wanted a recognition of true personhood within the meaning of the Fourteenth Amendment; and thus, that holding by this Court will remain forever based on a suit in which there was no true case or controversy on that specific point.

This Court has reeognized that this is a jurisdictional flaw, stripping the Court of its authority to have proceeded in *Roe* to a decision on such a point.[26] This Court has also recognized that this is especially important in cases involving constitutional questions.[27]

And this was no mere procedural jurisdictional defect, as would be the case if, for instance, a filing deadline had been missed. For then it could be argued that the jurisdictional defect could be limited to the parties of that case, and that the decision would be good law for all future cases. But this jurisdictional flaw, being substantive, means that there never even was, in contemplation of law, a bona fide case on this specific point. Consequently, reconsidering that point *de novo* and ruling the opposite way does not even constitute an instance of overruling precedent in the ordinary sense. For there has never even been a bona fide holding on that point, supported by the case or controversy requirement, for this Court to overrule to begin with.

The fact that these jurisdictional questions---whether there was a true case or controversy on the specific point of prenatal personhood, and whether the State of Texas had standing to assert such personhood---were decided implicitly

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[26] *GTE Sylvania, Inc. v. Consumers Union of the United States, Inc.*, 445 U.S. 375 (1980), *Craig v. Boren*, 429 U.S. 190 (1976), *Simon v. Eastern Kentucky Welfare Rights Organization*, 426 U.S. 26 (1976), *Flast v. Cohen*, 392 U.S. 83 (1968).

[27] Id. (*Simon and Flast.*)

in *Roe* does not preclude this Court from reexamining these questions *de novo*. As this Court has said,

> "Even as to our own judicial power or jurisdiction, this Court has followed the lead of Mr. Chief Justice Marshall who held that this Court is not bound by a prior exercise of jurisdiction in a case where it was not questioned and it was passed sub silencio." *Nathanson v. Labor Board*, 344 U.S. 25, 38 (1952), citing *United States v. More*, 3 Cranch 159, 172; *Snow v. United States*, 118 U.S. 346, 354; *Cross v. Burke*, 146 U.S. 82, 87; *Louisville Trust Co. v. Knott*, 191 U.S. 225, 236; and *Arant v. Lane* 245 U.S. 166, 170.

Also, later cases did not relitigate this point, but instead assumed the good law status of this Court's holding on that point.

B. There Is A Compelling Need, Based On *Martin v. Wilks*,[28] To Review This Issue *De Novo*.

Only last Term this Court reiterated one of the fundamental points of anglo-American law: No person's interest in life, liberty, or property shall be decided in any case in which such person is not a party to the proceedings.[29] That being the case, the need to reconsider the question of prenatal personhood in the case at bar is not optional; it is compelling.

C. Any Possible Objection To The Raising Of This Issue At This Stage Of The Proceedings Is Answered By *Hoe v. Wilson* and *Provident Tradesmen's Bank And Trust Co. v. Patterson*.

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[28] ___ U.S. ___, #87-1614, Slip opinion. Decided June 12, 1989.

[29] Id. at 4.

This Court has recognized that appellate courts must act *sua sponte* to defend the rights of nonjoined indispensable parties.[30]

This is in harmony with the principle stated in a long line of this Court's cases that an equity case can not proceed in the absence of such a party. *California v. Arizona*, 440 U.S. 59 (1979) (an action in equity can not be maintained without the joinder of indispensible parties), *Lumbermen's Mutual Casualty Co. v. Elbert*, 348 U.S. 48 (1954), *United Shoe Machinery Corp. v. U.S.*, 258 U.S. 451 (1922), *Niles-Bement Co. v. Iron Moulders Union*, 254 U.S. 77 (1920), *Swan Land And Cattle Co. v. Frank*, 148 U.S. 603 (1893), *Kendig v. Dean*, 97 U.S. (7 Otto) 423 (1876), *Railroad Co. v. Orr*, 85 U.S. (18 Wall.) 471 (1873) (all those entitled to litigate are necessary parties, even if their interest is remote), *Horn v. Lockhart*, 84 U.S. (17 Wall.) 570 (1873), *Ribon v. Railroad Companies*, 83 U.S. (16 Wall.) 446 (1872), *Shields v. Barrow*, 58 U.S. (17 How.) 130 (1854), *Mechanics Bank v. Seton*, 26 U.S. (1 Pet.) 299 (1828) (the relief granted will always be so modified as not to affect the interests of others), *Mallow v. Hinde*, 25 U.S. (12 Wheat.) 193 (1827).

D. A Decision By This Court Not To Reconsider This Issue Now Will Increase The Potential For Greater Upheaval In The Law Later On.

Time alone will not heal the jurisdictional defect of *Roe* with respect to its personhood holding. It will, in fact, only make it worse. The defect will always remain there, waiting for some future time when someone will raise this issue again and this Court, on another day, will hear arguments on the matter.

But by then the holdings of this Court, and of the lower and state courts, the extensive legislative schemes, and the expectations of the people themselves may be entrenched

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[30] *Provident Tradesmen's Bank and Trust Co. v. Patterson*, 390 U.S. 102, 110-111 (1968); *Hoe v. Wilson*, 76 U.S. (9 Wall.) 501, 504 (1869).

around the assumption of the validity of this Court's holding regarding personhood in *Roe*. Putting this issue off to hear it again at another day will only increase the chance that greater upheaval awaits us when that day finally does come.

At present the legal forces on both sides of this issue are prepared to discuss this matter at length and in detail. At present both sides are better prepared to argue and brief this issue than they have been in the entire history of the abortion debate. *Webster* has made both sides prepared for a comprehensive review of abortion, and this heightened state of preparedness may lose some of its intensity if it becomes slack due to disuse.

In *Roe*, by contrast, there was a great deal of confusion on the part of counsel and the justices as to what the basic biomedical facts of prenatal development are and as to just exactly how the case should be argued. At the original oral argument of the case, the following exchange took place.

Mr. Floyd: We say there is life from the moment of impregnation.

Question: And do you have any scientific data to support that?

Mr. Floyd: Well, we begin, Mr. Justice, in our brief, with the development of the human embryo, carrying it through to the development of the fetus, from about seven to nine days after conception.

Question: Well, what about six days?

Mr. Floyd: We don't know.

Question: But this statute goes all the way back to one hour.

Mr. Floyd: I don't---Mr. Justice, there are unanswerable questions in this field, I---

(Laughter.)

Question: I appreciate it; I appreciate it.

Mr. Floyd: This is an artless statement on our part.

Question: I withdraw the question.

(Laughter.)

Mr. Floyd: Thank you.[31]

At the oral reargument of the case, the following exchange took place.

Mr. Flowers: I wish I could answer (the question of how prenatal personhood should be decided). I believe that the Court must take these, the medical research, and apply it to our Constitution the best they can. I said I'm without envy of the burden that the Court has.

I think that possibly we have an opportunity to make one of the worst mistakes here that we've ever made, from the--I'm sorry.[32]

And immediately after these remarks, one justice referred to "conception" as "inception" three times.[33]

Counsel for Wade even went on to way, with respect to the "great clamoring" for the liberalization of abortion laws, "Perhaps this is good. Population explosion."[34]

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31 Tr. of Oral Arg. 22-23.
32 Tr. of Oral Rearg. 65.
33 Id.
34 Tr. of Oral Rearg. 67.

All of this confusion is understandable. The issue of abortion was brought to this Court when there had been as yet only a fraction of the debate either in society as a whole or in the legal community as to how the law should view all of the aspects of this issue. There was no lack of diligence on the part of counsel or the justices. The issue was just too much to absorb in the given limited time frame.

II. NEITHER THE OPINIONS OF JUSTICES REHNQUIST, WHITE, OR SCALIA, NOR THE LANGUAGE OR HISTORY OF THE FOURTEENTH AMENDMENT, PRECLUDE THE APPLICATION OF THE EQUAL PROTECTION CLAUSE TO PRENATAL HUMANS.

A. Even Opinions Of This Court---Much Less Opinions Of Individual Justices---Do Not Constitute Precedents For Points Decided *Sub Silencio*.

Contrary to what Justice Stevens implied in footnote thirteen of his opinion in *Webster*,[35] the opinions of his colleagues in *Webster* and in *Roe* do not preclude a finding by them that the Equal Protection Clause now applies to prenatal humans. Even though the issue of personhood was addressed by the court in *Roe*, the dissenting opinions of Justices Rehnquist[36] and White[37] addressed the subject of abortion in a context which did not squarely address the issue of prenatal personhood per se. The same is true for Justice Scalia's opinion in *Webster*.[38]

Thus, if those three opinions had actually been

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35 ___ U.S. ___, #88-605, Slip opinion (Stevens J., concurring in part and dissenting in part), at 10. (decided July 3, 1989).
36 410 U.S. at 171 and 223.
37 410 U.S. at 221.
38 *See supra* note 35, Slip opinion (concurring in part and concurring in the judgment).

opinions of this Court, even then they would not preclude the application of the Equal Protection Clause to prenatal humans. For this Court has long recognized that issues decided only implicitly are not precedents for later cases. *Webster v. Fall*, 266 U.S. 507, 511 (1925), *Edelman v. Jordan*, 415 U.S. 651, 672-673, n. 15 (1974).

B. The Jurisprudence Of Original Intent Must Not Be Confused With The Jurisprudence Of Original Result.

Advocates of the jurisprudence of original intent recognize that when the facts of today's life are applied to the principles of the Constitution, the result in fact can be different from what it would have been under the markedly different facts of what life was 200 years ago. As Judge Bork said in a concurring opinion in *Ollman v. Evans*,

> "Judge Scalia's dissent implies that the idea of evolving constitutional doctrine should be anathema to judges who adhere to a philosophy of judicial restraint. But most doctrine is merely the judge-made superstructure that implements basic constitutional principles. There is not at issue here the question of creating new constitutional rights or principles, a question which would divide members of this court along other lines than that of the division in this case. When there is a known principle to be explicated the evolution of doctrine is inevitable.[39]

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> "In a case like this, it is the task of the judge in this generation to discern how the framers' values, defined in the context of the world they knew, apply to the world we know. The world changes in which unchanging values find their application. The fourth amendment was framed by men who did not forsee

[39] *Ollman v. Evans*, 750 F.2d at 995 (1984) (Bork, J., concurring).

> electronic surveillance. But that does not make it wrong for judges to apply the central value of that amendment to electronic invasions of personal privacy.[40]

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> "So it is with defamation actions...Perhaps the framers did not envision libel actions as a major threat to that freedom. I may grant that, for the sake of the point to be made. But if, over time, the libel action becomes a threat to the central meaning of the first amendment, why should not judges adapt their doctrines?[41]

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> "To say that such matters must be left to the legislature is to say that changes in circumstances must be permitted to render constitutional guarantees meaningless. It is to say that not merely the particular rules but the entire enterprise of the Supreme Court in *New York Times v. Sullivan* was illegitimate.
>
> "We must never hesitate to apply old values to new circumstances, whether those circumstances are changes in technology or changes in the impact of traditional common law actions. *Sullivan* was an instance of the Supreme Court doing precisely this, as *Brown v. Board of Education* (citations omitted) was more generally an example of the Court applying an old principle according to a new understanding of a social situation. The important thing, the ultimate consideration, is the constitutional freedom that is given into our keeping. A judge who refuses to see new threats to an established constitutional value, and hence provides a crabbed interpretation that robs a provision of its full, fair and reasonable meaning, fails

[40] Id.

[41] 750 F. 2d at 996.

> in his judicial duty. That duty, I repeat, is to ensure that the powers and freedoms the framers specified are made effective in today's circumstances. The evolution of doctrine to accomplish that end contravenes no postulate of judicial restraint."[42]

And during the confirmation hearings for Judge Bork's appointment to this Court, the following exchange took place.

Sen. Specter: "...I think [*Brown v. Board of Education*] was...controversial because there was no legal underpinning for it."

Judge Bork: "Senator, I think there was [legal support for it], and let me say two things about it. One is that I have recently been told [that] it begins to look as if there is historical argument that the framers of the Fourteenth Amendment did not like segregation and may have intended to do away with it, but that [the] black codes and the segregation did not begin to come into the South until... the Northern troops left the South. And later the Supreme Court changed. *Plessy v. Ferguson*, after all, is a 1896 case, which is fairly long after the Fourteenth Amendment, *Plessy v. Ferguson* being the case that said separate but equal is all right.

"But passing that...historical evidence, which I think casts some doubt on the flat assumption that the Fourteenth Amendment really meant separate but equal, let me say this. They wrote a clause that does not say anything about separation. They wrote a clause that says 'equal protection of the laws'.

"I think it may well be true, as you suggest, Senator, that they had an assumption which they did not enact, but they had an assumption that equality could be achieved with separation. Over the years it became clear that that assumption would not be borne out in reality ever. Separation would never produce equality.

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[42] Id.

"I think when the background assumption [that equality could be achieved with separation] proved false, it was entirely proper for the court to say 'we will carry out the rule they wrote' and if [the framers of the Fourteenth Amendment] would have been a little surprised that it worked out this way, that is too bad. That is the rule they wrote and they assumed something that is not true.

"And in that way I do not think any damage is done---you can look at it more severely. You could say suppose they had written a clause that said 'we want equality and that can be achieved by separation and we want that too.'

"By 1954 it was perfectly apparent that you could not have both equality and separation. Now the court has to violate one aspect or the other of that clause, as I have framed it hypothetically. It seems to me that the way the actual amendment was written, it was natural to choose the equality segment, and the court did so. I think it was proper constitutional law, and I think we are all better off for it."[43]

This Court in *Roe*[44] (and Justice Stevens in *Webster*)[45] tried to paint pro-life advocates of judicial restraint into a corner by arguing that the doctrine of original intent dictates that the Equal Protection Clause is not applicable to prenatal humans. But the trap is only an illusion.

1. A Recognition Of Prenatal Personhood Produces The Same Result In Contemplation Of Law Today As Would Have Been Achieved In

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[43] Nomination of Robert H. Bork to be Associate Justice of the Supreme Court of the United States: Hearings before Comm. on the Judiciary, United States Senate, 100th Cong. 1st Sess., S. Hrg. 100-1011, Serial No. J-100-64, Part 1, pp. 285-286.

[44] 410 U.S. at 156-159.

[45] ___ U.S. ___, #88-605, Slip Opinion (Stevens, J., concurring in part and dissenting in part), at 10. (decided July 3, 1989)

1868, Even Though The Result In Fact Would Be Quite Different.

In 1868, following the adoption of the Fourteenth Amendment, it was lawful for the states to regulate concerning abortion---making it legal or illegal, as they saw fit---and unlawful for them to allow by law the killing of a certain class of human beings by withdrawing from that class the equal protection of the laws. Which view of prenatal personhood will uphold these same principles today?

If we accept the view that prenatal humans are not persons within the meaning of the Fourteenth Amendment, then today it certainly cannot be unconstitutional for abortion on demand to be legal, whether we accept *Roe* or not. But under such view, the Constitution supposedly accepts what we now know is the wholesale killing of an entire class of human beings.

On the other hand, if prenatal humans are persons, the states could not simply allow, with the sanction of law, the killing of this entire class of humans without due process. Granted, the penalties for abortion could vary considerably as compared to the homicide statutes. But the wholesale, carte blanche killing of members of this class without due process would be unconstitutional.

But, we may ask, would a recognition of prenatal personhood not also mean that the states would no longer be free to regulate abortion---to make it legal (or illegal) as they saw fit---as they were able to do in 1868?

No, it would not. A subtle but crucial distinction between abortion per se, and the actual killing of a prenatal human, must be recognized.

In contemplation of law the Constitution would not prohibit the states from making abortion legal; it would only prohibit them from making it legal to take the life of the prenatal person without due process in the performing of the abortion.

Granted, in the context of present medical technology, this would place the states' right to make abortion legal temporarily on hold in many of its applications; for it would probably mean that a state could make it lawful for a woman to terminate her pregnancy only after the child became viable, and that the pregnancy could be terminated only in a manner reasonably calculated to produce a live birth (i.e. by induced labor or by Cesarean section). Nevertheless, artificial gestational technology is on the rise, and the day may be near when the right of the states to make abortion legal carte blanche could be upheld *de facto* even if this Court recognizes prenatal personhood. Thus, though the question of prenatal personhood is central, *de facto*, to the right of the states to make abortion legal if they so choose, it is not central to the right of the states to do so *de jure*.

a. A finding of prenatal personhood would not overrule the basic premise of *Roe*.

The "irreducible minimum of *Roe*" is that "a woman has a limited fundamental constitutional right to decide whether to terminate a pregnancy."[46] A holding that prenatal humans must be afforded personhood status for purposes of the Fourteenth Amendment will not require overruling this basic premise. It would only mean that the states could not allow by law the taking of the life of the prenatal person without due process in the performing of the abortion.

Granted, this Court said in *Roe* that if prenatal humans were entitled to personhood status, the appellant Roe's case would "collapse".[47] In the context of *Roe* that was true enough. For there would have been no way in that case to terminate the pregnancy in question but by killing Jane Roe's prenatal daughter. Thus, any argument by appellant Roe about a right to terminate a pregnancy without killing the prenatal

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46 ___ U.S. ___, #88-605, Slip opinion (Blackmun, J., concurring in part and dissenting in part), at 19. (decided July 3, 1989).
47 410 U.S. at 156.

human would have been strictly academic except during the last stages of pregnancy. (Apparently, *Roe* was originally filed in the district court during the early stages of pregnancy.)

But now that the concept of a constitutional right to terminate a pregnancy is part of our case law, this court can address the issue of prenatal personhood separately, leaving intact the concept of a constitutional right to terminate a pregnancy, and affecting only its applications. As this Court has said,

> "An error as to the applicability of a principle to a unique factual situation does not mean that the principle itself has been rejected."[48]

Again, as would be the case with the retained, though dormant, right of the states to make abortion legal, present medical technology would place much of *Roe* temporarily on hold in its applications; and, unless self-defense were applicable, a woman could terminate her pregnancy only after the child became viable. And likewise, the pregnancy could be terminated only in a manner reasonably calculated to produce a live birth. But artificial gestational technology may soon enable us to vindicate the important interests of women announced in *Roe* without threatening the life of the prenatal person. Thus, though the question of prenatal personhood is central to the *de facto* application of the rights of women announced in *Roe*, it is not central to the validity of those rights in *Roe de jure*.

Granted, this Court said in *Roe* that the State of Texas could not, by adopting one theory of life, override the right to terminate a pregnancy.[49] But by that point in *Roe* this Court had already found that prenatal humans would not be afforded personhood status within the meaning of the Fourteenth

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48 *Flora v. U.S.*, 362 U.S. 145, 168, n. 34 (1960).
49 410 U.S. at 162

Amendment.[50] Thus, this Court was not saying that the constitutional status of personhood, if separately established, could not override the interests of the mother; rather, it was only saying that a mere theory of personhood, which it has already found to be of less than the constitutional status of personhood, could not override such interests.

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50 410 U.S. at 156-159.

Special thanks to Bill Anderson and Bob Weed for their assistance in the preparation of this brief.

CONCLUSION

This Court should overrule *Roe v. Wade* on the specific, limited issue of prenatal personhood, reverse the court of appeals in the case at bar, and remand the case to the district court for hearings on the following question:

Whether prenatal humans must be afforded personhood status within the meaning of the Fourteenth Amendment?

In the alternative, the Court should reverse the court of appeals and remand the case to the district court for hearings on the following question:

Whether the holding in *Roe v. Wade* that prenatal humans are not persons within the meaning of the Fourteenth Amendment was supported by the case or controversy requirement?

In either case the Court should instruct the district court to appoint a guardian ad litem to represent those prenatal humans who might be affected by the outcome of the litigation.

Respectfully submitted,

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August 31, 1989

AMICUS CURIAE

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BRIEF AMICUS CURIAE OF THE NATIONAL RIGHT TO LIFE COMMITTEE, INC. IN SUPPORT OF APPELLANTS IN *TURNOCK* AND CROSS-PETITIONERS IN *HODGSON*

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QUESTION PRESENTED HEREIN

Is the decision of this Court in *Roe v. Wade* sufficiently implicated in the cases at bar, *Turnock v. Ragsdale* and *Minnesota v. Hodgson*, for *Roe v. Wade* to be reconsidered?

TABLE OF CONTENTS

Page:

Question Presented Herein i

Table Of Contents ii

Table of Authorities v

Interest Of Amicus 2

Summary Of Argument 3

Argument 4

Introduction 4

I. A Logical, Coherent Analysis Governing The Constitutional Necessity For This Court To Decide A Constitutional Issue Is Discernible From Precedent 5

A. Four Elements Govern the Consitutional Necessity of Deciding A Constititutional Issue Under this Court's Precedents 5

1. This Court has a duty to interpret the Constitution 5

2. This Court's duty to interpret the Constitution is limited by Article III of the Constitution . 7

3. This Court's duty to interpret the Constitution is limited by its jurisdictional statutes 8

4. This Court's duty to interpret the Constitution is limited by prudential considerations 9

B. These Four Elements Form a Logical, Sequential Analysis to be Employed in Analyzing the Necessity of Deciding a Constitutional Issue 10

C. Consideration of Some Specific Questions Concerning Reconsideration Reveal that Reconsideration of *Roe v. Wade* Is Appropriate in this Case 11

II. The Failure Of This Court To Agree Upon And Follow Such An Analysis Concerning Reconsideration Has Introduced Chaos Into The Law And Into This Court 15

A. That this Court Has Not Agreed Upon an Analysis for Reconsideratilon Is Evident from this Past Term 15

B. *Roe v. Wade* Demonstrates the Overreaching Possible with an Inadequate Analysis and the Resultant Overruling Required 17

C. *Webster* Demonstrates the Underreaching Possible with an Inadequate Analysis and the Resultant Chaos Attending Such Action 19

1. Is the *Roe* trimester scheme overruled *sub silentio?* 21

2. Is the abortion right now a liberty interest? . 22

3. Is *Akron* overruled *sub silentio* by rehabilitation of the unduly burdensome test? 23

III. Employing The Proper Analysis To The Issue Of Reconsideration Herein Reveals That *Roe v. Wade* Should Be Reconsidered In These Cases 24

A. This Court Should Go Through the Full Analysis to Determine What Issues Should be Decided and on What Grounds 24

B. The Issue of Reconsideration Itself Is Not One Which This Court May Avoid if It Chooses to Decide These Cases and Issue a Written Opinion

Because *Roe* and its Right and Analysis are Clearly Implicated 25

1. Compelling state interests in maternal health and unborn life, which underlie these statutes, are asserted throughout pregnancy 26

2. The right to effecutate the abortion decision is implicated 27

3. The right to consult one's physician in making the abortion decision is forbidden 27

Conclusion 29

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Cases *Pages*

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Commonwealth Edison Co. v. Montana, 453 U.S. 609 (1981) 14

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Doe v. Bolton, 410 U.S. 179 (1973) 2

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Mapp v. Ohio, 367 U.S. 643 (1961) 14

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28 U.S.C. § 1331 8

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On Petition for a Writ of Certiorari to the United States
Court of Appeals for the Eighth Circuit

BRIEF AMICUS CURIAE OF THE NATIONAL RIGHT TO LIFE COMMITTEE, INC. IN SUPPORT OF APPELLANTS IN *TURNOCK* AND CROSS-PETITIONERS IN *HODGSON*

INTEREST OF AMICUS[1]

The National Right to Life Committee, Inc. is a nonprofit organization whose purpose is to promote respect for the worth and dignity of all human life, including the life of the unborn child from the moment of conception. The National Right to Life Committee, Inc. is comprised of a Board of Directors representing 51 state affiliate organizations and more than 2,000 local chapters made up of individuals from every race, denomination, ethnic background, and political belief. It engages in various political, legislative, legal, and educational activities to protect and promote the concept of the sanctity of innocent human life.

The members of the National Right to Life Committee, Inc. have been the prime supporters of laws restricting abortion on demand to only those instances in which the mother's life is in danger. Since *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973), the members of the National Right to Life Committee, Inc. have supported legislation to protect unborn human life within these guidelines. The Illinois and Minnesota legislation at issue herein is the result of lobbying, in great part, by the members of the National Right to Life Committee, Inc. and its Illinois and Minnesota affiliates, Illinois Federation for the Right to Life and Minnesota Citizens Concerned for Life. By means of this brief, the National Right to Life Committee, Inc. seeks to advance these interests by supporting the Minnesota regulations at issue herein.

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[1] This Brief Amicus Curiae is filed with the consent of all parties to this appeal. A letter from each attorney stating this consent has been filed with the Clerk of this Court.

SUMMARY OF ARGUMENT

In *Webster v. Reproductive Health Services*, members of the majority differed on whether and to what extent *Roe v. Wade* should be reconsidered. From the decisions of this Court, a logical, coherent, and sequential analysis may be constructed to govern when it is necessary to decide a constitutional issue, in fulfillment of this Court's constitutional duty to decide a case properly before it. Failure to follow this analysis has resulted in anomalous results, evident in the decisions of this Court in the last term, and confusion in the law, evident in the wake of *Webster*.

Applying this analysis, it is clear that reconsideration of precedent is required whenever a case is brought on the basis of the right and/or analysis created in that precedent. The right declared and the analysis to be employed in constitutional review are but means of applying the Constitution. The ultimate question in constitutional review is what the Constitution requires. This is always at issue in constitutional review, making the case declaring a right and/or analysis always at issue in such cases. Thus, the Court must always establish the standard of review, either implicitly or explicitly, in determining the constitutionality of a statute.

Furthermore, a court is required to give a reasoned, legal justification for its decision. This must resolve those constitutional issues embraced by an analysis of the case. This requires resolution of the issues associated with the standard of review. Thus, a precedent which establishes a constitutional right or sets forth the analysis to be employed in determining the constitutionality of a statute under that right must be reconsidered whenever the constitutionality of a statute is challenged on the basis of that right or employing that analysis. Therefore, reconsideration of *Roe v. Wade* may not be avoided in the cases at bar.

Moreover, although sufficient implication of *Roe* for reconsideration of that case is inherent in its seminal status, the

cases at bar implicate *Roe's* core analysis more fully than did *Webster.* Additionally, the confusion created by *Webster* itself implicates the heart of Roe's analysis, making reconsideration based upon the effect of that decision alone a constitutional necessity. Therefore, *Roe v. Wade* should be reconsidered in the cases at bar.

ARGUMENT

INTRODUCTION

The decision of this Court in *Webster v. Reproductive Health Services*, 109 S.Ct. 3040 (1989), settled the small portion of abortion jurisprudence encompassed by the Missouri statutes at issue in that case. But *Webster* settled these matters in a way which unsettled the remainder of abortion law.

Issues now unresolved go to the very core of this Court's opinion in *Roe v. Wade*, 410 U.S. 113 (1973). Were *Roe* and/or its later progeny overruled sub silentio in *Webster?* Is a woman's interest in obtaining an abortion a fundamental right, a limited fundamental right, or a liberty interest? Will abortion legislation now be reviewed under the traditional compelling interest standard or is an unduly burdensome analysis the de facto standard? What is an undue burden? Is the trimester scheme overruled or yet viable? Must abortion regulations be narrowly tailored to effectuate the underlying state interest or only reasonably related to the interest?

This confusion arose from the inability of the members of this Court to agree on the analysis to be employed in determining when constitutional necessity requires the reconsideration of precedent. The majority which decided Webster disagreed over whether and to what extent *Roe v. Wade* should be reconsidered. A particular focus of the debate was the "necessity" principle employed by this Court to "avoid [] passing upon a large part of all the constitutional questions pressed upon it for decision . . . , notwithstanding conceded jurisdiction, until *necessity* compels it in the performance of *constitutional duty.*"

Rescue Army v. Municipal Court of Los Angeles, 331 U.S. 549, 569 (1947)(emphasis added).

This Court has never set forth, in one place, the full analysis by which to determine when the necessity exists which compels this Court to fulfill its constitutional duty to decide a constitutional issue. By reviewing the duties and limitations imposed upon this Court by the Constitution, its jurisdictional statutes, and prudence, one may discern a clear pattern. This brief sets out this pattern, logically organizing the duties and limitations of this Court into a coherent analysis. This analysis is then applied to determine whether reconsideration of *Roe v. Wade* is constitutionally necessary in the cases at bar.

I. A LOGICAL, COHERENT ANALYSIS GOVERNING THE CONSTITUTIONAL NECESSITY FOR THIS COURT TO DECIDE A CONSTITUTIONAL ISSUE IS DISCERNIBLE FROM PRECEDENT.

A. FOUR ELEMENTS GOVERN THE CONSTITUTIONAL NECESSITY OF DECIDING A CONSTITUTIONAL ISSUE UNDER THIS COURT'S PRECEDENTS.

Four elements govern whether, in a particular case, the decision of a constitutional issue is necessary in the performance of constitutional duty: (1) a constitutional duty to say what the law is, (2) a constitutional limitation of decision opportunities to cases and controversies, (3) a statutory limitation on subject matter jurisdiction, and (4) prudential principles imposed by this Court upon itself for sound jurisprudential reasons.

1. THIS COURT HAS A DUTY TO INTERPRET THE CONSTITUTION.

"It is emphatically the province *and duty* of the judicial department to say what the law is." *Marbury v. Madison*, 1 Cranch 137, 177 (1803)(emphasis added). So declared this Court in the famous case of *Marbury v. Madison*, in which it deter-

mined the Constitution to be the supreme law of the land, governing even enactments of Congress. *Id.* at 177-79. This Court also decided in *Marbury* that it had authority to review actions of other elements of government to determine whether they comported with this Court's declaration of "what the law is" with respect to the Constitution. *Id.*

This Court could most comprehensively fulfill its duty to declare what the law is by publishing its own commentary on the law, in the manner of William Blackstone or Lord Coke. Of course, such a project would be of immense and prohibitive proportions, and no commentary could cover every conceivable issue.

More significantly, however, this Court is prohibited from roaming about the constitutional field in such a manner by its constitutional charter. There are limits placed upon its power and duty to say what the law is, which are set forth in detail below.

However, these limitations must not be employed to avoid deciding matters which this Court has a duty to decide. Professor Gunther has styled as a neo-Brandeisian fallacy the misuse of the "necessity" principles set forth by Justice Brandeis in his concurrence to *Ashwander v. TVA*, 297 U.S. 288, 346-48 (1936)(Brandeis, J., concurring), to support a view that this Court has a general discretion not to adjudicate. *See generally* G. Gunther, *The Subtle Vices of the "Passive Virtues" — A Comment on Principle and Expediency in Judicial Review*, 64 Colum. L. Rev. 1 (1964)(commenting on the content and uses of the *Ashwander* rules). *Cf.* Wechsler, "Toward Neutral Principles of Constitutional Law," in *Principles, Politics, and Fundamental Law (1961).*

The duty to decide, when constitutionally required, is illustrated by Justice Marshall in Marbury, where he felt compelled, in giving a legal justification for his decision, to comment on matters not necessary to the decision of the case but necessary to a legal justification of the case. He wrote:

> The peculiar delicacy of this case, the novelty of some of its circumstances, and the real difficulty attending the points which occur in it, require a complete exposition of the principles on which the opinion to be given by the court is founded.

Marbury, 1 Cranch at 154. To this comment must be added another of Justice Marshall's remarks in the case of *Cohens v. Virginia*, 6 Wheat 264, 404 (1821):

> Questions may occur which we would gladly avoid; but we cannot avoid them. All we can do is to exercise our best judgment and conscientiously to perform our duty.[2]

2. THIS COURT'S DUTY TO INTERPRET THE CONSTITUTION IS LIMITED BY ARTICLE III OF THE CONSTITUTION.

The Constitution of the United States allows this Court to interpret the Constitution only in relation to "Cases . . . arising under this Constitution." U.S. Const. art. III, § 2.

From this limitation arise certain rules, which Justice Brandeis set forth in his concurring opinion to *Ashwander v. TVA*, 297 U.S. at 346-48 (1936)(Brandeis, J., concurring). These rules apply even where jurisdiction is conceded under the controlling jurisdictional statutes, *id.* at 346, for they are constitutionally mandated by Article III.

Justice Brandeis set forth these rules as follows:

First, "[t]he Court will not pass upon the constitutionality of legislation in a friendly, non-adversary, proceeding. *Id.* at 346.

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[2] This brief does not enter into the debate over this Court's discretion to decline the exercise of jurisdiction. It merely addresses the necessity of deciding all elements of a case which are required in giving a legal justification for this Court's decision in a case which is decided by this Court. Your amicus does not believe that the standard of review is an issue which may properly be avoided. It is different in kind from construing a statute to avoid constitutional difficulty or deciding a case on procedural grounds to avoid a constitutional issue.

Second, "[t]he Court will not 'anticipate a question of constitutional law in advance of the necessity of deciding it,'" nor will it "'decide questions of a constitutional nature unless absolutely necessary to a decision of the case.'" *Id.* at 346-47 (citations omitted).[3]

Third, "[t]he Court will not pass upon the validity of a statute upon complaint of one who fails to show that he is injured by its operation." Id. at 347.

Fourth, "[t]he Court will not pass upon the constitutionality of a statute at the instance of one who has availed himself of its benefits." Id. at 348.

3. THIS COURT'S DUTY TO INTERPRET THE CONSTITUTION IS LIMITED BY ITS JURISDICTIONAL STATUTES.

Pursuant to its authority to "ordain and establish" federal courts, U.S. Const. art. III, § 1, Congress has enacted jurisdictional statutes which require a "deprivation, under color of any State law, statute, ordinance, regulation, custom or usage, of any right, privilege or immunity secured by the Constitution of the United States" or a claim "arising under the Constitution, laws, or treaties of the United States" for federal district court jurisdiction. 28 U.S.C. §§ 343(3) and 1331. Without satisfaction of these prerequisites, the cases at bar should not have come before this Court by way of the lower federal courts.[4] Similarly,

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[3] As noted *infra*, the question of establishing the appropriate standard of review is a necessary decision to this Court's constitutional review of a case and not a discretionary matter which may be avoided if convenient.

[4] In addition to establishing the proper standard of review, this Court must also examine its jurisdiction. As noted in text, this Court only has jurisdiction over these cases if there is yet a constitutional right to abortion.

In *Bender v. Williamsport Area School District*, 475 U.S. 534 (1986), this Court declared that "every federal appellate court has a special obligation to 'satisfy itself not only of its own jurisdiction, but also that of the lower courts

(footnote continued)

had these cases come up through state courts, this Court could only have heard them if the statutes at issue were "repugnant to the Constitution" or if a constitutional right were claimed. 28 U.S.C. § 1257.

4. THIS COURT'S DUTY TO INTERPRET THE CONSTITUTION IS LIMITED BY PRUDENTIAL CONSIDERATIONS.

Self-imposed, prudential principles have been developed by this court, based upon policy considerations. These rules were summarized in Justice Brandeis' *Ashwander* concurrence as follows:

First, "[t]he Court will not 'formulate a rule of constitutional law broader than is required by the precise facts to which it is applied.'" *Ashwander*, 297 U.S. at 347 (Brandeis, J., concurring)(citations omitted).

Second, "[t]he Court will not pass upon a constitutional question although properly presented by the record, if there is also present some other ground upon which the case may be disposed of." *Id.*

Third, "'[w]hen the validity of an act of the Congress[5] is drawn in question, and even if a serious doubt of constitutionality is raised, it is a cardinal principle that this Court will first ascertain whether a construction of the statute is fairly possible by which the question may be avoided.'" *Id.* at 348 (citation omitted).

Footnote 4 continued
in a cause under review,' even though the parties are prepared to concede it." *Id.* at 541 (citation omitted). The question of jurisdiction is a "fundamental" one, which "the Court is bound to ask and answer for itself, even when not otherwise suggested, and without respect to the relation of the parties to it." *Bender*, 475 U.S. at 547. Thus, in determining whether subject matter jurisdiction lies in the present case, this Court must carefully consider *Roe*, the case upon which federal jurisdiction rests.

[5] This principle has been extended to acts of state legislatures, as well. *See, e.g., Thornburgh v. American College of Obstetricians and Gynecologists*, 737 F.2d 283, 294 (1984).

B. THESE FOUR ELEMENTS FORM A LOGICAL, SEQUENTIAL ANALYSIS TO BE EMPLOYED IN ANALYZING THE NECESSITY OF DECIDING A CONSTITUTIONAL ISSUE.

These duties and rules may be arranged in logical, sequential order. The result is conceptually similar to a series of increasingly fine filters; the analysis filters cases, then issues, and then grounds of decision at subsequent levels until only those which are properly to be decided remain. The phases of the analysis are as follows:

1. *Is there a case or controversy?* Logic compels that initial consideration be given to the requirements of the Constitution, which authorized creation of this Court and granted it powers within the jurisdiction to be prescribed by Congress. Justice Brandeis' four rules dealing with Article III, set forth above, are properly asked at this point. These questions determine whether a concrete, adversarial context exists for the resolution of constitutional issues. They prevent abstract decisions on hypothetical points.

2. *Is there jurisdiction?* Logic likewise compels that the jurisdictional statutes be next examined. Congress further defined the jurisdiction of this Court and created the lower courts and limited their jurisdiction by these statutes. These statutes require, in part relevant herein, that a suit must be initiated based upon the violation of a constitutional right.

If there is an Article III case and jurisdiction exists, then the case itself is properly before this Court, whether it arrives by grant of a writ of certiorari or by appeal.

3. *Are there prudential reasons for avoiding certain aspects of the case?* At this point, the three prudential rules of Justice Brandeis' *Ashwander* principles must be considered. Is there some statutory or procedural basis for decision by which a constitutional decision may be avoided? May a statute be construed in a manner favoring constitutionality? If a constitutional decision must be made, what are the narrowest possible grounds upon which it may be properly made?

This last question must be asked in light of this Court's duty both to say what the law is by interpreting the Constitution when required and by its judicial duty to give the legal basis for its decision in a reasoned manner. Reasoned exposition of all elements of the analysis which are logically required in order to give an explanation of that legal basis of the decision must be deemed necessary to the decision.

The proper filtering analysis decides first which cases must be heard, then — employing prudential considerations — what issues must be heard, and finally what grounds must logically be given to support the decision. Prudence requires that the fewest possible issues be resolved on the lowest level of grounds required. The required grounds are all those necessary to logically justify the decision. This analytically includes the standard — the constitutional analysis — to be employed. Without such a determination, the decision has not been legally and logically justified.

C. CONSIDERATION OF SOME SPECIFIC QUESTIONS CONCERNING RECONSIDERATION REVEAL THAT RECONSIDERATION OF *ROE v. WADE* IS APPROPRIATE IN THIS CASE.

Finally, some specific questions with regard to reconsideration have arisen in the opinions of this Court. These questions have already been settled and require brief exposition at this point.

First, *must the parties ask for reconsideration?* No. Necessity of reconsideration of a constitutional issue is not determined by whether the parties have requested reconsidera-

tion.[6] Just last term, in *Patterson v. McClean Credit Union*, 109 S.Ct. 2363 (1989), this Court reconsidered *Runyon v. McCrary*, 427 U.S. 160 (1976), without any request from the parties. *Patterson*, 109 S.Ct. at 2380 (Brennan, J., dissenting)("I find it disturbing that the Court has in this case chosen to reconsider, without any request from the parties . . . .").

Second, *is it sufficient for reconsideration if the right created by a prior case is the basis of the claim in a later case?* Yes. This is the basis upon which the Court reconsidered the *Patterson* case. In *Patterson*, the plaintiff brought an action based upon the statutory right created by an interpretation of 42 U.S.C. § 1981 in *Runyon*, 427 U.S. 169, i.e., that § 1981 encompasses a private contract between an employer and employee. It is a more difficult task where a prior case is not as directly implicated as to provide the right upon which the suit is founded. This is evident in *South Carolina v. Gathers*, 109 S.Ct. 2207 (1989), decided by this Court last term. In *Gathers*, Justices O'Connor and Kennedy and Chief Justice Rehnquist, in dissent, decided that the holding of the prior case of *Booth v. Maryland*, 482 U.S. 496 (1987), was not sufficiently implicated for reconsideration of that case. *Id.* at 2212 (O'Connor, J., dissenting, joined by Rehnquist, C.J., and Kennedy, J.). This was so because *Gathers* involved prosecutorial comments about a criminal victim's character in closing argument, not in the submission of evidence which *Booth* forbade. Thus, *Booth* was not sufficiently implicated for Justices O'Connor and Kennedy and Chief Justice Rehnquist to reconsider that case. *Id.* at 2211.

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[6] *In Thornburgh v. American College of Obstetricians and Gynecologists*, Justice O'Connor implied that she would not reach the issue of reconsideration of *Roe v. Wade* because the parties had not asked the Court to do so. 106 S.Ct. at 2213. However, in *Akron v. Akron Center for Reproductive Health*, she personally reached the issue of *Roe's* constitutional correctness and declared much of it unconstitutional, despite the fact that the parties had not asked the Court to reconsider *Roe*, a point which she expressly noted. 462 U.S. at 458, 452. Further, in *Webster*, she declared her willingness to reconsider Roe in a proper case.

Justice Scalia would have overruled *Booth*, *id.* at 2217-18, as, apparently, would have Justice White. *Id.* at 2211.

Third, *may this Court decide a case on broader principles than reasonably required by the precise facts of the case before it in appropriate circumstances?* No, but it must resolve a sufficient number of constitutional issues to give a reasoned, legal justification for its decision. This properly includes a decision concerning the standard of review, i.e., in this case, whether or not the analysis of *Roe v. Wade* is still good law. It may also include resolution of other matters not required by a simple judgment of affirmation or reversal which are, however, necessary to give a legal justification for the decision rendered. This question is often erroneously framed as whether a decision may be made on a broader than necessary basis. When "necessary" is properly understood to encompass those matters necessary to giving the required legal justification for a decision, the confusion is resolved. The rule, then, is that no Court should declare a rule of constitutional law broader than required by the precise facts of the case, but that this concept includes matters, such as resolving the appropriate standard of review (even if that requires reconsideration of precedent), necessary to giving a reasoned, legal justification for the decision.[7]

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[7] Many examples exist where this Court has decided issues it felt necessary to giving a legal justification for its decision but has been criticized for reaching issues not necessary under the facts of the case. Because all matters necessary to a legal justification of an opinion are required but decision of other matters is not permitted, the question of what matters ought to be addressed in an individual case is one subject to differing judgment. In *City of Richmond*, 109 S.Ct. 706 (1989), Justice O'Connor, writing for the Court, authored an opinion which went beyond the facts to state a set of governing principles — presumably to give legislative bodies guidance in developing the law. *Id.* at 735. This was observed by Justice Marshall, writing for the dissent. *Id.* at 752 (Marshall, J., dissenting)("the majority has gone beyond the facts of this case to announce a set of principles"). In another case from last term, *Perry v. Leeke*, 109 S.Ct. 609 (1989), this Court reached an issue which Justice Kennedy did not feel was necessary to the decision. *Id.* at 602

(footnote continued)

This principle explains Justice Marshall's decision in *Marbury* to comment on matters required for giving a legal justification for the Court's decision. He expressed both his sensitivity to avoiding overbroad decisions and the need to resolve those constitutional issues required for a legal justification of his opinion. In discussing the issue of whether a mandamus could go to the Secretary of State, he wrote, "It may not be proper to mention this position; but I am compelled to do it." *Marbury*, 1 Cranch at 149. He was compelled to do it because of this Court's duty to provide a reasoned, legal justification for its ruling. He commented, "These observations are premised solely for the purpose of rendering more intelligible those which apply more directly to the particular case under consideration." *Id.* at 156.[8]

Footnote 7 continued
("In view of our ruling, it is quite unnecessary to discuss whether prejudice must be shown when the right to counsel is denied. I would not address that issue . . . ."). Other cases where the Court has been accused of deciding more broadly than the precise facts required are *Daniels v. Williams*, 474 U.S. 327 (1986); *Illinois v. Gates*, 462 U.S. 213 (1983); *Michelin Tire Corp. v. Wages*, 423 U.S. 276 (1976); *Pointer v. Texas*, 380 U.S. 400 (1965); and *Mapp v. Ohio*, 367 U.S. 643 (1961). The Court has even expressly acknowledged its broader than strictly required holding in some cases, such as *Commonwealth Edison Co. v. Montana*, 453 U.S. 609 (1981), and *Perez v. Campbell*, 402 U.S. 637 (1971).

Acknowledging that resolution of all issues necessary to a reasoned legal justification of this Court's decision is required but that going beyond that is forbidden resolves the tension between the practice of this Court in the cases above and its rule against overly broad decisions.

[8] Much debate has raged over Justice Marshall's decision, *see e.g.*, Van Alstyne, *A Critical Guide to Marbury v. Madison*, 1969 Duke L.J. 1, including the criticism that, given its conclusion, the Court should have said only that it lacked jurisdiction. Much of what was said in the early part of the opinion, regarding the propriety of issuing mandamus against an executive's illegal acts, might be characterized as *obiter dictum*. Indeed, Thomas Jefferson, the contemporary President and a key player in the *Marbury* drama, insisted throughout his life that most of *Marbury* was "merely an obiter dissertation of the Chief Justice." *Jefferson to Justice William Johnson, June*

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I. THE FAILURE OF THIS COURT TO AGREE UPON AND FOLLOW SUCH AN ANALYSIS CONCERNING RECONSIDERATION HAS INTRODUCED CHAOS INTO THE LAW AND INTO THIS COURT.

The disagreement on this Court over the analysis to be applied with regard to reconsideration of precedent is evident in three cases from last term where reconsideration was considered and treated in three different ways. The chaotic results which flow from this failure to agree on an analysis are illustrated by two abortion cases, *Roe v. Wade* and *Webster v. Reproductive Health Services*. The former overreached, causing this Court in *Akron* to overrule part of that decision. The latter underreached, creating chaos in abortion law. Either approach is wrong, both for sound jurisprudential reasons and because of the illicit results.

A. THAT THIS COURT HAS NOT AGREED UPON AN ANALYSIS FOR RECONSIDERATION IS EVIDENT FROM THIS PAST TERM.

In this past term, this Court considered three key cases in which reconsideration was proposed. The inconsistent manner in which these were handled reveals the lack of an agreed analysis for reconsideration.

In the first case, *Patterson v. McClean Credit Union*, 109 S.Ct. 2363, this Court plenarily reconsidered *Runyon v. McCrary*, 427 U.S. 160. There was no disagreement among the majority over whether reconsideration should occur, although, as noted *supra*, neither party asked for reconsideration and the sole implication of the prior decision was that it created the right under which the action was brought.

Footnote 8 continued
12, 1823, I S. Car. His. & Gen. Mag. 1, 9-10 (1900). Justice Marshall himself later called some of his statements about Article III in *Marbury* unduly broad and partially rejected them in *Cohens v. Virginia*, 6 Wheat 264 (1821). Nonetheless, the fact that he may have erred by going somewhat beyond what was required to give a legal justification for his decision does not vitiate the principle. His error, if any, was of degree and not of principle.

In the second case, *Webster v. Reproductive Health Services*, 109 S.Ct. 3040, the members of the majority could not agree that reconsideration was proper even though *Roe v. Wade* created the right under which the action was brought. And such reconsideration as was called for was not plenary, with the exception of that proposed by Justice Scalia. The plurality declared that only the trimester scheme was implicated and Justice O'Connor thought that nothing of Roe was implicated.[9]

As argued in this brief, however, distinguishing the degrees of implication of a seminal case — one which creates the right or analysis under which the cause of action arose — is unnecessary. Such a case is always fully implicated in a cause which invokes that right or analysis. Such distinguishing of degrees of implication was not engaged in in *Patterson*, nor is it appropriate under the principle that the decision of all matters necessary to a reasoned justification of the Court's decision — including establishment of the standard of review — is constitutionally necessary. The result of the failure of this Court to employ a consistent analysis with regard to reconsideration resulted in turmoil and confusion in abortion jurisprudence, as more fully set forth *infra*. It further resulted in the failure of a majority of this Court to address a decision, *Roe*, which five Justices have declared to be constitutionally flawed.

In the third case, *South Carolina v. Gathers*, 109 S.Ct. 2207 (1989), the very decision-making process of the potential working majority in that case was disrupted by its inability to agree on an analysis regarding reconsideration. It is apparent from the opinions in Gathers that five Justices of this Court believe that *Booth v. Maryland*, 482 U.S. 496 (1987) — the case which created the right of criminals not to have evidence of their

[9] It must be noted that Justice O'Connor viewed the Missouri statute as not inconsistent with *Roe* or its progeny because it did not "unduly burden" the abortion right. However, this unduly burdensome or "absolute obstacle" test, championed in *Akron* by Justice O'Connor, and under which she would have upheld the ordinances at issue in *Akron*, was expressly rejected by this Court as violative of *Roe v. Wade*. *Akron*, 462 U.S. at 420 n.1.

victim's character introduced at trial — was wrongly decided. The result, however, was the extension of the reach of *Booth v. Maryland* to prosecutorial statements about the victim's character.

While judicial restraint is admirable and required by sound, constitutional jurisprudence, it is improperly applied to avoid considering the precedent which creates the foundational right upon which a cause is brought. Consideration of that foundational right, and the case creating it, is essential in giving a reasoned, legal justification for this Court's decision in any case based upon that right. The havoc wrought by this Court's failure to consistently apply the sort of analysis proposed herein is further illustrated in two cases, *Roe* and *Webster*.

B. *ROE v. WADE* DEMONSTRATES THE OVERREACHING POSSIBLE WITH AN INADEQUATE ANALYSIS AND THE RESULTANT OVERRULING REQUIRED.

Roe demonstrates both the matters necessary to deciding a constitutional issue and the perils in deciding those that are not necessary.[10] The *Roe* majority correctly began by establishing the proper standard of review, to which it devoted the majority of the opinion. Given its judgment that the Texas criminal abortion statute — excepting only cases of risk to maternal life — was unconstitutional, the Court needed to decide the issues necessary to give a reasoned, legal justification of its decision. To merely strike down the Texas statute, without explanation, would not have fulfilled this Court's constitutional duty to declare what the Constitution means when deciding the case.[11]

[10] This, of course, in no way concedes any correctness as to the substantive holdings of the *Roe* Court.

would not have fulfilled this Court's constitutional duty to declare what the Constitution means when deciding the case.[11]

Necessary to a reasoned, legal justification of this Court's decision in *Roe* was its holding that there is a fundamental right to abortion. Likewise, a holding that no compelling interests extended throughout pregnancy was vital to the analysis. *Roe* also demonstrated proper restraint in not deciding the issues of paternal rights and parental rights (of parents with minors seeking abortion). *Roe*, 410 U.S. at 165 n.67. Deciding these issues, which were not presented by the facts, would have decided constitutional questions in advance of the necessity of doing so. In Article III terms, no case existed with respect to these matters, and, therefore, this Court was without constitutional authority to decide them.

Unnecessary to a reasoned, legal justification of the decision in *Roe* was creation of the trimester scheme. Also unnecessary were the inherently legislative declarations, such as the statement that a hospitalization requirement for post-first-trimester abortions was constitutionally permissible. The Court reached these issues in advance of the necessity of deciding them, violating Article III, and it decided matters more broadly than required by the facts, violating prudence. The *Roe* majority ought to have awaited another case involving a viability line to reach a discussion of viability. It should have decided the maternal health line in a case properly presenting that issue, such as a case requiring hospitalization for abortions after a certain point.

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[11] Of course, this Court has the power to summarily affirm or reverse decisions in appropriate circumstances. However, constant reliance on such a practice would not comport with this Court's duty to decide. Practically, such a practice would also unduly prolong the trial and error, see-saw interaction between this Court and the legislatures in their attempt to pass constitutional legislation. Such considerations, however, do not justify overreaching beyond what is necessary to give a reasoned, legal justification of a decision.

The imprudence of such premature decision-making was demonstrated in the progeny of *Roe*, especially in the case of *Akron v. Akron Center for Reproductive Health*. 462 U.S. 416 (1983). In *Akron*, the majority found it necessary both to alter the trimester scheme, precipitously created in *Roe*, and to reject a post-first trimester hospitalization requirement, prematurely approved in *Roe*. *Akron*, 462 U.S. at 435-47.[12]

Thus, *Roe* well illustrates how a court may begin correctly and then go astray by overreaching. A proper analysis would preclude such overreaching.

C. *WEBSTER* DEMONSTRATES THE UNDERREACHING POSSIBLE WITH AN INADEQUATE ANALYSIS AND THE RESULTANT CHAOS ATTENDING SUCH ACTION.

By contrast with *Roe*, the *Webster* amalgam of opinions did not even begin correctly. Neglected was the essential first step in constitutional analysis, the determination of the standard of review — the constitutional analysis — to be employed in reviewing the statutes at issue. The core issue in any constitutional challenge to a statute is whether the statute comports with the Constitution — not whether it complies with a prior decision of this Court. Deciding whether a statute conforms to the requirements of some precedent is but a shorthand way of asking whether constitutional requirements are met. Therefore, it is essential to the analysis to determine what the Constitution requires. In a matter already decided, this question is answered by citation to precedent, the principles of which are applied to the new fact situation. But in each subsequent case, the question of what the Constitution requires must be asked. It may be simply answered by reaffirmation of the precedent, either express or implicit, but it must be

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[12] *See* Bopp & Coleson, *The Right to Abortion: Anomalous, Absolute, and Ripe for Reversal*, 181 B.Y.U. J. Pub. L. 181, 202-07 (1989)(discussing this disregard of stare decisis at length).

answered. The Constitution is at issue in constitutional adjudication.

Therefore, in *Webster*, the constitutionality of *Roe v. Wade*, *was* before this Court. It could not properly be avoided. The standard of review, by which the Constitution is applied to determine the constitutionality of a statute, must be decided. It is not of a nature permitting avoidance until some more convenient time or some greater implication. If a case is brought to declare a statute unconstitutional on the basis of the decision establishing the right and setting forth the analysis, then that case is implicated. Once implicated, it must be applied, modified, or overruled; its reconsideration is then proper. A state need not reenact the Texas statute struck down in *Roe* before this Court may properly reconsider *Roe*.

Deciding the standard of review as a necessary first step in constitutional analysis is something one may not avoid by prudential principles. It is inherent in constitutional review. It is the very essence of constitutional review, serving as the link between the statutes reviewed and the Constitution. It is not of the same nature as a constitutional challenge to a statute which may be avoided by a permissible construction of the statute. Nor is it of the same nature as a constitutional challenge to a statute which may be avoided by deciding a matter on a statutory, procedural, or independent state law basis. The issue of the correct standard of review arises *precisely when the Court has been unable to avoid a constitutional question and must determine whether a statute is constitutional*. It is *inherently necessary* to decide in the discharge of this Court's constitutional duty and may not properly be avoided.

Therefore, *Webster* underreached — the Court did not fulfill its duty to say what the law is in justifying its decision. The resulting chaos demonstrates clearly why strict adherence to a sound analysis with regard to deciding constitutional matters, and especially the standard of review, is essential to sound constitutional adjudication. Indeed, the chaos created by *Webster* alone is sufficient to call this Court to say what the law is in the cases at bar.

The confusion resulting from *Webster* may be seen in the varying interpretations given to the opinion, which run along a spectrum from a *sub silentio* reversal of *Roe*, to a *sub silentio* reversal of the trimester scheme and this Court's most recent pronouncements in *Akron* and *Thornburgh*, to a mere funding case with few other implications. In light of such diversity of possibilities, how may the legislatures act? What is permitted?

One may of course say that nothing was overruled in *Webster*, for the Court used no such language. However, the notion of *sub silentio* reversal is a commonplace in the law. And is the meaning of a case circumscribed by its proper holding? The legitimate holding of *Roe* — if legitimacy be limited to that permitted by the narrowest holding based upon the specific facts — was but the tip of the iceberg which comprised the full meaning of *Roe* for abortion jurisprudence.

Justice Oliver Wendell Holmes declared that the state of the law is nothing more than a prediction of what a court will do at a given time with a given set of facts. Holmes, *The Path of the Law*, 10 Harv. L. Rev. 457 (1897). Employing this analysis of legal realism, the meaning of *Webster* may be determined by examining the statements of various Justices, both in *Webster* and before, to determine what elements of abortion jurisprudence yet enjoy majority support. The result of such analysis raises significant questions.

1. IS THE *ROE* TRIMESTER SCHEME OVERRULED *SUB SILENTIO?*

It appears from the opinions in *Webster* that majority support for the trimester scheme of *Roe* has disappeared. Justice O'Connor declared her belief that a state has a compelling interest in unborn life and maternal health throughout pregnancy in her earlier dissents to *Akron* and *Thornburgh*. *Thornburgh*, 476 U.S. at 828 (O'Connor, J., dissenting)("I . . . remain of the views expressed in my dissent in *Akron*. The State has

compelling interests in ensuring maternal health and in protecting potential human life . . . throughout pregnancy."). With Chief Justice Rehnquist and Justices White, Scalia[13], and Kennedy saying the same thing in *Webster*, it is readily apparent that a majority of this Court has now recognized these two interests as existing throughout pregnancy, indicating the demise of the trimester scheme. *Webster*, 109 S.Ct. at 3057.

But this Court has not stated this demise in express language. Will legislatures feel free to act upon it? By comparison with the small area of the law this Court settled in *Webster*, the areas it unsettled are immense, going to the core of *Roe v. Wade*.

2. IS THE ABORTION RIGHT NOW A LIBERTY INTEREST?

Similarly, the very nature of a woman's interest in choosing abortion is now unclear. In *Roe*, this Court determined that a woman has a fundamental right to choose abortion, employing a substantive due process analysis. The *Webster* plurality declared that a woman has only a "liberty interest" in abortion under the Due Process Clause of the Fourteenth Amendment. *Webster*, 109 S.Ct. at 3058. Justice O'Connor, with her advocacy of the rational basis standard of review in most cases, agrees that there is no general, fundamental right to abortion. *Akron*, 462 U.S. at 453 (O'Connor, J., dissenting). However, where there is an undue burden, she might find a fundamental right, evidenced by her requiring a compelling state interest to justify regulation of abortion in such cases. *Id.* Thus, there is now a majority of the Court which no longer believes that there is a general fundamental right to abortion. But what is the law? What does the Constitution require?

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[13] As Justice Scalia would reverse *Roe*, it is assumed that, to the extent a fundamental right to abortion is given continued recognition, he would agree that there are offsetting compelling interests in maternal health and unborn life.

3. IS *AKRON* OVERRULED *SUB SILENTIO* BY REHABILITATION OF THE UNDULY BURDENSOME TEST?

In *Akron*, this Court found the unduly burdensome test to be an unconstitutional form of analysis, forbidden by the dictates of *Roe v. Wade* itself. *Akron*, 462 U.S. at 420 n.1. Logically then, any invocation of, or reliance upon, the unduly burdensome test would be in direct derogation of *Roe*. However, in *Webster*, Justice O'Connor readily relied upon this analysis to uphold the statutes at issue in *Webster* and to declare that all of the Missouri statute could be upheld under prior decisions of this Court, at the same time arguing that no prior abortion decision of this Court was sufficiently implicated for purposes of reconsideration. *Webster*, 109 S.Ct. at 3060. At a very minimum, however, the resurrection of the unduly burdensome test implicated *Akron*, directly rejecting a key holding of that decision.

Is the unduly burdensome test — as the lowest common denominator of the current majority on abortion issues — the proper analysis to be employed by lower courts and legislatures? If *Akron* is indeed overruled *sub silentio*, is legislation such as that found in *Akron* and in *Thornburgh* now constitutional?

A further problem arises if Justice O'Connor's lowest-common-denominator analysis is now the *de facto* analysis for review of abortion legislation. It has been generally thought since *Roe* that the fundamental rights analysis required the showing (1) that the state has a compelling interest and (2) that the legislation enacted is narrowly tailored to effect only the compelling interest. *Roe*, 410 U.S. at 155. But Justice O'Connor wrote in *Akron:*

> The Court has never required that state regulation that burdens the abortion decision be 'narrowly tailored' to express only the relevant state interest. In Roe, the Court mentioned 'narrowly drawn' legislative enactments, but the Court never actually adopted this standard in the Roe analy-

sis. In its decision today, the Court fully endorsed the Roe requirement that a burdensome health regulation, or as the Court appears to call it, a 'significant obstacle' be 'reasonably related' to the state compelling interest. The Court recognizes that '[a] state necessarily must have latitude in adopting regulations of general applicability in this sensitive area.'

Akron, 462 U.S. at 467 n.11 (O'Connor, J., dissenting)(citations omitted and case names not italicized in original). Which standard must abortion legislation now meet — must it be narrowly tailored or rationally related to a compelling interest?

In sum, *Webster* has thrown abortion jurisprudence into disarray. The very core analysis of *Roe* has been placed in question: as to the nature of the interest, as to the standard of review, as to the temporal extent of the states' compelling interests, and as to the second prong of the *Roe* analysis for legislation burdening (unduly or not?) a fundamental right — if indeed, there is yet a fundamental right. And if the unduly burdensome test controls, what does unduly mean? This chaos alone compels this Court to perform its constitutional duty, which it avoided in *Webster* but which exists in these cases, to say what the law is.

III. EMPLOYING THE PROPER ANALYSIS TO THE ISSUE OF RECONSIDERATION HEREIN REVEALS THAT *ROE v. WADE* SHOULD BE RECONSIDERED IN THESE CASES.

A. THIS COURT SHOULD GO THROUGH THE FULL ANALYSIS TO DETERMINE WHAT ISSUES SHOULD BE DECIDED AND ON WHAT GROUNDS.

It is beyond the scope of this brief — which addresses reconsideration of *Roe v. Wade* — to apply the analysis herein in all of its respects to the statutes at bar. This Court should take this opportunity to employ a systematic approach to determine what issues should be decided and on what grounds. However,

if this Court decides to consider the constitutionality of any part of the statutes at issue herein, i.e., it finds that it cannot avoid them by decisions on other than a Constitutional basis, then it should reconsider *Roe*, which is the nexus between the Constitution and the statutes. *Roe v. Wade*, as both the source of both the right and analysis to be employed in constitutional review is clearly implicated for purposes of reconsideration.

B. THE ISSUE OF RECONSIDERATION ITSELF IS NOT ONE WHICH THIS COURT MAY AVOID IF IT CHOOSES TO DECIDE THESE CASES AND ISSUE A WRITTEN OPINION BECAUSE *ROE* AND ITS RIGHT AND ANALYSIS ARE CLEARLY IMPLICATED.

In giving a reasoned, legal justification for any decision reached in these cases, the Court must set forth the proper constitutional analysis to be employed. This requires reconsideration of *Roe v. Wade*. It is inherent in the analysis as discussed at length above.

Moreover, although further "implication" is not required, it is certainly present in these cases. These cases more directly implicate *Roe*, in terms of involving more of its analysis and affecting more periods of pregnancy, than did *Webster*. Unlike *Webster*, which largely involved funding matters (already settled in principle by this Court) and regulation after viability (where compelling state interests exist even under *Roe)*, the cases at bar implicate three key elements of *Roe*, the compelling interests in unborn life and maternal health throughout pregnancy, the right to effectuate the abortion decision, and the right to make the abortion decision in consultation with one's physician. The statutes at issue in these cases, therefore, directly impinge upon the right to abortion created in *Roe* to an even greater extent than in *Webster*.

1. COMPELLING STATE INTERESTS IN MATERNAL HEALTH AND UNBORN LIFE, WHICH UNDERLIE THESE STATUTES, ARE ASSERTED THROUGHOUT PREGNANCY.

Underlying the Minnesota parental notice statute at issue in *Hodgson* are compelling state interests in unborn human life and in protecting traditional family authority and vulnerable minors. Indeed, the Minnesota parental notice statute has had the demonstrated effect of reducing the adolescent abortion rate — dramatically furthering the State's compelling interest in protecting unborn human life.[14] Yet this statute applies throughout pregnancy, not just after viability.

Furthermore, underlying the Illinois clinic statute at issue in *Turnock* are the State's compelling interests in maternal health and in unborn life. These likewise apply throughout pregnancy. The State's compelling in protecting maternal health is the

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[14] Statistics from the Minnesota Department of Health indicate that in Minnesota during 1975-80, before the parental notice statute went into affect, minors showed the following annual patterns:

1. Pregnancies increased from 4142 to 4360 = an increase of 5%.

2. Births decreased from 2494 to 2033 = a decrease of 19%.

3. Abortions increased from 1648 to 2327 = an increase of 41%.

In the period from 1981-86, following enactment of the statute the following patterns emerged:

1. Pregnancies decreased from 4360 to 3171 = a decrease of 27%.

2. Births decreased from 2033 to 1626 = a decrease of 20%.

3. Abortions decreased from 2327 to 1545 = a decrease of 34%.

Data from Minnesota Department of Health (adjusted for population fluctuation).

There is no evidence that this dramatic drop in the abortion rate resulted from teens leaving the state to obtain abortions. Blum, Resnick & Stark, *The Impact of Parental Notification Law on Adolescent Abortion Decision-Making*, 77 AJPH 619, 620 (1987).

principle justification of this regulatory scheme. The State's interest in protecting unborn life, however, is also advanced by the provision requiring counseling concerning alternatives to abortion. Ill. Rev. Stat. ch. 111 1/2, para. 205.730(b)(3). This counseling is intended, in part, and has the effect, to cause women to more seriously consider alternatives to abortion, thereby decreasing the number of abortions. Unborn lives are thereby saved.

Thus, for purposes of reconsideration, the holdings of *Roe* that the state's compelling interests in maternal health only arise after the first trimester and in unborn life after viability are squarely contradicted. In contrast, *Webster* involved only the State's compelling interest in unborn life after viability.

2. THE RIGHT TO EFFECTUATE THE ABORTION DECISION IS IMPLICATED.

The right to effectuate the abortion decision is also guaranteed by the decisions of this Court. *Roe*, 410 U.S. at 163. Under the Illinois statute at issue in *Turnock*, first trimester abortion clinics are thoroughly regulated. This again implicates a key holding of *Roe* that regulation of the abortion decision and its effectuation must be left to the woman and her physician in the first trimester. After that, regulation is only permitted for protection of the woman's health. In this case, it is asserted that such regulations are not indicated for the protection of maternal health, and, in any event, these regulations extend into the forbidden zone of the first trimester. For purposes of reconsideration, *Roe* is sufficiently implicated.

3. THE RIGHT TO CONSULT ONE'S PHYSICIAN IN MAKING THE ABORTION DECISION IS FORBIDDEN.

Finally, a direct and absolute bar to one of *Roe's* key elements is present in the Illinois provision (at issue in *Turnock*) which prevents anyone with a monetary interest in the performance of the abortion decision from counseling a woman concerning her abortion decision. Ill. Rev. Stat. ch. 111 1/2, para.

205.730(b)(2)(D). As interpreted by the lower courts, this provision directly conflicts with *Roe*'s provision that a woman is free to make her abortion decision "in consultation with her physician," *Roe*, 410 U.S. at 163, because it forbids this consultation. A key holding of *Roe* is therefore implicated, which justifies reconsideration of that case.

In sum, this Court ought to reconsider *Roe v. Wade* if it decides any constitutional issue in this case; because establishing the standard of review and confirming the right under which the case is brought are essential to the analysis of constitutionality; because explication of the standard of review is necessary to providing a reasoned, legal justification for the judgment; and because key aspects of *Roe* are implicated by the statutes themselves.

CONCLUSION

For the reasons given herein, this Court should reconsider *Roe v. Wade* in its consideration of the cases at bar. Upon reconsideration, this Court should determine that the doctrine of stare decisis does not preclude the reversal of *Roe v. Wade*,[15] *that, under the correct test for fundamentality,*[16] *there is no fundamental right to abortion in the history and tradition of our nation,*[17] *and that, therefore, Roe v. Wade* should be reversed.

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[15] *See* Brief Amici Curiae of the Hon. Christopher H. Smith, Alan B. Mollohan, Vin Weber, Robert K. Dornan, Earl Hutto, John La Falce, Virginia Smith, Bill Emerson, Henry H. Hyde, and Gordon J. Humphrey, Members of the Congress of United States, in Support of Appellants in *Turnock* and Cross-Petitioners in *Hodgson*.

[16] *See* Brief Amicus Curiae of Free Speech Advocates in Support of Appellants in *Turnock v. Ragsdale*.

[17] *See* Brief Amicus Curiae of the American Academy of Medical Ethics in Support of Appellants in *Turnock* and in Support of Cross-Petitioners in *Hodgson*.

AMICUS CURIAE

BRIEF

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Nos. 88-790, 88-1309

IN THE

Supreme Court of the United States

OCTOBER TERM 1989

No. 88-790

BERNARD J. TURNOCK et al., *Appellants*,

v.

RICHARD M. RAGSDALE et al., *Appellees*.

On Appeal from the United States Court of Appeals for the Seventh Circuit

No. 88-1309

STATE OF MINNESOTA et al., *Cross-Petitioners*,

v.

JANE HODGSON et al., *Cross-Respondents*.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

BRIEF AMICUS CURIAE OF THE AMERICAN ACADEMY OF MEDICAL ETHICS IN SUPPORT OF APPELLANTS IN *TURNOCK* AND CROSS-PETITIONERS IN *HODGSON*

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TABLE OF CONTENTS

Page:

TABLE OF AUTHORITIES iii

INTEREST OF THE *AMICUS CURIAE* 1

SUMMARY OF THE ARGUMENT 1

ARGUMENT 2

I. *Roe v. Wade*, Based upon Erroneous Notions of the Historical Status of Abortion under the Common Law, Broke Sharply with Long Established Traditions and Values of the Common Law and our Constitution 2

A. In England, from the Beginning of the Common Law, Courts and Other Respected Authorities Consistently Condemned Abortion 6

B. From Earliest Times, English Law Prohibited Parents from Killing Unwanted Children, and Parliament and the Courts Took Strong Steps, Gradually Strengthened through the Centuries, to Punish Violations of Those Prohibitions 11

C. Early in the Colonial Period, These Laws Were Received with Full Rigor in the United States . 17

D. When Abortion Became More Common than Infanticide with the Development of Technical Means for Aborting a Woman with a Lessened Danger to Her Life, English and American Law Came to Emphasize Abortion as the Primary Evil 19

II. *Roe v. Wade* Should be Overruled and the Resolution of the Competing Claims of Mothers and Their Offspring Should Be Returned to the Legislative Branches of Government 23

A. Changes in Medical Technology Are Central to a Proper Resolution of the Controversies over Abortion 23

B. Legislatures Are Best Placed to Explore Appropriate Regulatory Responses to Changing Reproductive Technologies 26

C. If *Roe v. Wade* Is to Continue to Survive in Some Form, the Court Must Continually Reexamine, as It Did in *Webster v. Reproductive Health Services*, the Application of the *Roe* Criteria in Light of New Medical Technology 28

CONCLUSION 30

APPENDIX A: WHAT REALLY HAPPENED IN *REX v. de BOURTON*? 1a

APPENDIX B: OTHER REPRESENTATIVE COMMON LAW CASES ON ABORTION 1b

Agnes' Appeal (1200) 1b

Gundwine's Appeal (1247) 1b

Juliana's Appeal (1256?) 2b

Rex v. Anonymous (1348) 2b

Rex v. Lichefeld (1505) 3b

Cockaine v. Witnam (1577) 5b

Regina v. Turnour (1581) 6b

Regina v. Sims (1601) 6b

Regina v. Webb (1602) 7b

Proprietary v. Mitchell (1652) 8b

Rex v. Beare (1732) 11b

Rex v. Tinkler (1781) 15b

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Bowers v. Hardwick, 478 U.S. 186 (1986) 3

City of Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416 (1983) 27, 28

City of Richmond v. J.A. Croson Co., 109 S. Ct. 706(1989) 26

Colautti v. Franklin, 439 U.S. 379 (1979) 26, 27

Colony v. Allen, Newport Cnty. Gen. Ct. Trials: 1671-1724A n.p. (Sept. 4, 1683 sess.) 17

Colony v. Powell (Va. 1635), 7 Am. L. Rec. 43 (1954) ... 18

Commonwealth v. Bangs, 9 Mass. 387 (1812) 22

Commonwealth v. Parker, 50 Mass. (9 Met.) 263 (1845) 22

Doe v. Bolton, 410 U.S. 179 (1973) 25, 26, 27

Dougherty v. People, 1 Colo. 514 (1872) 22

Harris v. McRae, 448 U.S. 297 (1980) 27

In re the Stillbirth of Agnita Hendricks' Bastard Child (Del. 1679), Ct. Rec. of New Castle on Del. 1676-1681 at 274-275 (1904) 17

Lamb v. State, 67 Md. 524, 10 A. 208 (1887) 22

McCulloch v. Maryland, 17 U.S. (4 Wheat.) 316 (1819) 3

Meyer v. Nebraska, 262 U.S. 390 (1923) 3

Mills v. Commonwealth, 13 Pa. 630 (1850) 22

Mitchell v. Commonwealth, 78 Ky. 204 (1879) 22

New State Ice Co. v. Liebman, 285 U.S. 262 (1932) 28

People v. Sessions, 58 Mich. 594, 26 N.W. 291 (1886) ... 22

Planned Parenthood Assn. v. Ashcroft, 462 U.S. 476 (1983) 27

Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52 (1976) 27, 28

Proprietary v. Brooks, 10 Md. Archives 464-465, 486-488 (1656) 17

Proprietary v. Lambrozo, 53 Md. Archives 387-391 (1663) 17

Proprietary v. Mitchell, 10 Md. Archives 171-186 (1652) [quoted in Appendix B] 17

Proprietary v. Robins, 41 Md. Archives 20 (1658) 17

Robins v. Robins, 41 Md. Archives 85 (1658) 17

Roe v. Wade, 410 U.S. 113 (1973) .. 2, 3, 11, 19, 23, 24, 26, 27

Simopolous v. Virginia, 462 U.S. 506 (1983) 26, 27

State v. Crook, 16 Utah 212, 51 P. 1091 (1898) 22

State v. Gedicke, 43 N.J.L. 86 (1881) 22

State v. Howard, 32 Vt. 380 (1859) 22

State v. Moore, 25 Iowa 128 (1868) 22

State v. Murphy, 27 N.J.L. 112 (1858) 21

Thornburgh v. American College of Obstetricians, 476 U.S. 747 (1986) 26, 27

United States v. Carolene Prod. Co., 304 U.S. 144 (1938) 27

Webster v. Reproductive Health Services, 109 S. Ct. 3040 (1989) 28

United States Constitution

Fourteenth Amendment 3

American Statutes and Ordinances

Charters & Gen'l L. of the Colony & Prov. of Mass. Day 293 (Dane, Prescott & Story. . . (1814) 18

Ill. Rev. Code sec. 46 (1827) 25

Me. Rev. Stat., ch. 160, secs. 13, 14 (1840) 25

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Beale v. Beale, 24 Eng. Rep. 373 (K.B. 1713) 10

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Cecily's Appeal (1249), C. Meekings, *Studies in 13th Century Justice and Administration* 257 (no. 562) (1981) 6

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Juliana's Appeal (1256?), Somerset Pleas (Civ. & Crim.) from the Rolls of the Itinerant Justices 321 (no. 1243) (C. Chadwyck-Healey ed. 1897) 4

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Modi's Appeal j(1221), 59 Selden Soc'y 560-561 (no. 1336) (1940) 7

Orscherd's Appeal (1249?), Just. 1/174, m.40d 6, 11

Paiards's Appeal (1249?), Just. 1/174, m.40d 6

Philippa's Appeal (1276?), The London Eyre of 1276 at 51 (no. 187) (London Rec. Soc'y 1976) 7, 11

Phina's Appeal (1246), Just. 1/778, m.57 6

Porte's Appeal (1249), Just. 1/175, m.38 4

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R. v. Anonymous, M. Hale, *History of Pleas of the Crown* 429 (1685) 10

R. v. Anonymous (1803), 3 J. Chitty, *Criminal Law* 798-801 (1816) 20

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INTEREST OF THE *AMICUS CURIAE*

This brief is filed under Supreme Court Rule 36, with the consent of the parties, on behalf of the American Academy of Medical Ethics as *amicus curiae* in support of Appellants in *Turnock* and Cross-Petitioners in *Hodgson*. The Academy is an educational and lobbying organization with approximately 20,000 physician members, incorporated in 1986 to respond to the challenges to established medical ethics emerging in recent decades. The Academy follows the Hippocratic Oath in opposing abortion except to save the life of the mother. The Academy sees an unborn child as a patient deserving protection and the full advocacy of attending physicians. The Academy asks the Court to overrule *Roe v. Wade* or, as in *Webster v. Reproductive Health Services*, to reconsider its application in light of current medical technology.

SUMMARY OF THE ARGUMENT

The majority in *Roe v. Wade* appraised the values implicated in that case by an extended discussion of the history of abortion, reaching erroneous conclusions about the status of abortion under the common law and breaking sharply with the traditional values embodied in the common law and our Constitution. Although conviction for abortion was rare in England before the Eighteenth Century, abortion, along with other killing of unwanted children, was condemned by respected authorities from the beginning of the common law—as illustrated by the strong steps through the centuries, by Parliament and the courts, to punish infanticide. The laws respecting abortion and infanticide applied with full rigor in the United States throughout the colonial era. When new medical technologies lessened the danger to the mother from abortion, abortion became more common than infanticide, and legal institutions turned their attention to abortion.

Abortion has always been socially controlled in the interest

of both the child and the mother, interests that have continually changed as new medical technologies developed. Changes in the technology of abortion altered the maternal interest in obtaining the procedure, while developing reproductive technologies reinforced increasing certainty that a conceptus is a "person" from the earliest stages of gestation. The moral and legal implications of such technical developments are not merely medical questions; such implications raise questions of social policy and values.

Legislatures are better placed than courts to devise appropriate regulatory responses to rapidly changing human reproductive technologies because legislatures are better able to assemble the information necessary to assess the import of the changing data in balancing of the interests created or reinforced by those technologies. Courts are ill-suited to sit as boards of review for the implications of changing medical technologies. In the present state of flux, the model of states as laboratories for social policies is especially apt.

For the foregoing reasons, *Roe v. Wade* should be overruled. If *Roe v. Wade* is to continue to survive in some form, the Court will find itself, as in *Webster v. Reproductive Health Services*, caught up in a continual reexamination of the application of the *Roe* criteria in light of the constantly changing medical technology.

ARGUMENT

I. *Roe v. Wade*, Based upon Erroneous Notions of the Historical Status of Abortion under the Common Law, Broke Sharply with Long Established Traditions and Values of the Common Law and our Constitution

More than half of the majority opinion in *Roe v. Wade*, 410 U.S. 113, 129-152, 156-162 (1973), was given to a history of abortion, using this history to inform the values at stake in the controversy before the Court. This approach is hardly surprising as the Court has long interpreted the open-textured language of the Constitution through resort to underlying legal

and social traditions forming the background against which the Constitution was written. *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316 (1819). The liberty guaranteed by the due process clause of the Fourteenth Amendment particularly includes "those privileges long recognized in common law as essential to the orderly pursuit of happiness" by free people. *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923). That liberty is fundamental if it is "deeply rooted in this Nation's history and traditions." *Bowers v. Hardwick*, 478 U.S. 186, 192 (1986). Thus, historical errors, and flawed inferences drawn from those errors, would seriously undermine the entire edifice built on *Roe v. Wade*.

The majority in *Roe v. Wade* concluded that "it now appear[s] doubtful that abortion was ever established as a common law crime", 410 U.S. at 136, and that abortion statutes in the United States were not generally adopted until after the Civil War (i.e., after the Fourteenth Amendment was adopted). *Id.* at 139. Both conclusions are wrong.

While research has not uncovered any record of actual punishment[1] for abortion in England before 1732 *if* the abortion was voluntarily undertaken by a woman without serious injury to herself *or* without a live birth before the death of the child, indictments and appeals of felony[2] have been found back at least to 1200 for abortion without either aggravating factor.[3]

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[1] Often the only records extant are terse notes of an indictment which do not indicate what happened at trial. Many of these records do note a finding of "not guilty" rather than a dismissal of the proceeding. *See* note 9 *infra*.

[2] Many of the indictments and appeals in this brief have not been published in the United States. The most important unpublished cases are *R. v. Webb* (Q.B. 1602), *infra*, and *R. v. Beare* (Q.B. 1732), *infra*. I am grateful to Dr. John Keown, of the University of Leicester, for providing me with the text of these and some other early cases. *See generally* J. Keown, *Abortion, Doctors and the Law* (1988). I am also indebted to Mr. Philip Rafferty of Los Angeles, who made available his research and that of Dr. J.H. Baker, of St. Catherine's College, Cambridge University. Dr. Baker's book, *An Introduction to English Legal History* (2d ed. 1979), is a leading text for the study of the topic.

[3] *See, e.g., R. v. Portere* (K.B. 1400), The Shropshire Peace Role 1400-1414

(footnote continued)

Later, a woman was indicted for self-abortion; apparently, she was saved from punishment only by a general pardon. *R. v. Webb* (Q.B. 1602), Calendar of Assize Rec., Surray Indictments, Eliz. I at 512 (no. 3146) (J. Cockburn ed. 1980).[4] Less than 12 months earlier, a court had held a man for murder when an abortus died after being born alive. *R. v. Sims*, 75 Eng. Rep. 1075 (Q.B. 1601). Secondary authorities on the common law and judicial dicta also frequently condemned abortion.

Against that background, beginning with "Lord Ellenborough's Act" in 1803, 43 Geo. III, c. 59, criminal statutes expressly prohibiting abortion spread rapidly throughout the common law world. In the United States, 70% of the states (with 85% of the American population) had such statutes by 1861. By 1895 abortion was clearly a serious crime in every state.[5]

Footnote 3 continued

at 57-58 (no. 24) (E. Kimball ed. 1959); *R. v. Botevylayn* (K.B. 1305), Wiltshire Gaol Delivery & Trailbaston Trials 1275-1306 at 105, 126, 131 (nos. 576, 800, 854) (R. Pugh ed. 1978); *Juliana's Appeal* (1256?), Somerset Pleas (Civ. & Crim.) from the Rolls of the Itinerant Justices 321 (no. 1243) (C. Chadwyck-Healey ed. 1897); *Porte's Appeal* (1249), Just. 1/175, m.38; *Sauter's Appeal* (1221), Pleas of the Crown for Gloucester Cnty. 1221 at 16 (no. 69) (F. Maitland ed. 1884); *R. v. le Petiprestre* (1244), The London Eyre of 1244 at 48 (no. 116) (London Rec. Soc'y 1970); *Sibil's Appeal* (1203), 1 Selden Soc'y 32 (no. 73) (1887); *Agnes' Appeal* (1200), 1 Selden Soc'y, *supra* at 39 (no. 82). Abortion was covered by even earlier compilations of the common law, which required payment of a full *wergeld* (a money payment to relatives of a slain person to settle the claims for homicide) if the child were "living", and a half-*wergeld* if not "living". *Leges Henri Primi* c. LXX.14 (L.J. Downer ed. 1972). [This was a 12th Century compilation of sources on Anglo-Saxon law as modified by the early Norman kings.] Several of the cases noted here were settled by money payments, perhaps as *wergeld*.

[4] Whether the pardon came before or after conviction is unclear, although the editor of the records infers that Webb was convicted before she was pardoned, Keown, *supra* note 2, at 173 n.23.

[5] *See generally* Dellapenna, *The History of Abortion: Technology, Morality, and Law*, 40 U. Pitt. L. Rev. 359, 389-407 (1979); Quay, *Justifiable Abortion—Medical and Legal Foundations (Pt. II)*, 49 Geo. L.J. 395 (1961); Witherspoon, *Reexamining Roe: Nineteenth-Century Abortion Statutes and the Fourteenth Amendment*, 17 St. Mary's L.J. 29 (1985).

The majority in *Roe* relied heavily, and uncritically, on the work of Professor Cyril Means.[6] Means' history of abortion was neither objective nor accurate. Nor have these inadequacies been resolved by James Mohr's somewhat different history of abortion.[7] Mohr and his followers would shift the focus from an increasingly clear history of the law of abortion to the far less certain issue of the "true" social attitudes concerning abortion. Mohr's approach simply discounts records of attitudes he disagrees with either in favor of other, similar records of attitudes he finds useful, or even in favor of presumed unrecorded opinions of historically mute classes.

Such purportedly sociological approaches to history never stoop to explain why, if the publicly expressed attitudes of formal social institutions did not represent the true values of the society, those institutions chose to express themselves in such unrepresentative terms, or why these terms continue through major changes of social and political structure. This approach does permit one to infer almost at will what the true attitudes were, but it overlooks that the Constitution is a legal document. Ultimately, legal traditions must inform the Constitution; the social, medical, and moral context is useful only to illuminate those legal traditions, and not as an independent source of claims of right. Rather, the unbroken legal tradition, extending over more than seven centuries of social life, condemning abortion and other aggression against unwanted children, is the distillation of the moral sense of the community.

[6] Means, *The Phoenix of Abortional Freedom: Is a Penumbral Right of Ninth-Amendment about to Arise from the Nineteenth-Century Legislative Ashes of a Fourteenth-Century Common-Law Liberty?*, 17 N.Y.L.F. 335 (1971) (hereafter cited as Means II); Means, *The Law of New York Concerning Abortion and the Status of the Foetus, 1664-1968: A Case of Cessation of Constitutionality*, 14 N.Y.L.F. 411 (1968) (hereafter cited as Means I). The majority cited Means seven times during its depiction of the history of abortion—without noting that he was then the general counsel of the National Association for the Reform of Abortion Laws (now the National Abortion Rights Action League).

[7] J. Mohr, *Abortion in America* (1978).

A. In England, from the Beginning of the Common Law, Courts and Other Respected Authorities Consistently Condemned Abortion

Indictments of abortionists at common law were far more common than was thought in 1973.[8] Common law indictments and appeals of felony for abortion are recorded as early as 1200. While the terse records do not indicate any punishment, the many clear records of judgments of "not guilty" demonstrate that the indictments and appeals were valid under the common law.[9]

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[8] Abortion was also punished by the ecclesiastical courts of the time. *Before the Bawdy Court* 81, 152, 172, 204, 238 (nos. 150, 369, 427, 531) (P. Hair ed. 1972); Keown, *supra* note 2 at 5; Helmholz, *Infanticide in the Province of Canterbury in the Fifteenth Century*, 2 Hist. Childhood Q. 379, 380-381 (1975). That a crime was punished in ecclesiastical courts does not establish that it was not punishable at the common law. Keown, *supra*; Helmholz, *supra* at 386. Nor does ecclesiastical interest indicate that such prosecutions must be seen as religiously based: many modern legal topics that today are unquestionably secular, such as wills, slander, and enforcement of simple contracts, originated in the ecclesiastical courts. 1 W. Holdsworth, *A History of English Law* 65-77, 455-457, 580-632 (1938); 3 Holdsworth at 408-428, 441-454, 534-536; 5 Holdsworth at 167-169, 197-218, 291-299; 8 Holdsworth at 301-307, 324-417; 15 Holdsworth at 198-208; Dellapenna, *supra* note 5, at 382-387. Also, in English legal theory both temporal and ecclesiastical courts derived their authority from the Crown, and thus both together represented the "law of England". 1 M. Hale, *History of the Pleas of the Crown*, preface (1685).

[9] *See R. v. Cokkes* (1415), 7 Calendar of Inquisitions Misc. (Ch.) Preserved in the Pub. Rec. Off. 1399-1422 at 296 (no. 523) (1968); *Gras's Appeal* (1276?), The London Eyre of 1276 at 73-74 (no. 261) (London Rec. Soc'y 1976); *Sorel's Appeal* (1276?), Eyre of 1276 at 61 (no. 222); *Serlo's Appeal*, Eyre of 1276 at 62-64 (nos. 157-158); *Cecily's Appeal* (1249), C. Meekings, *Studies in 13th Century Justice and Administration* 257 (no. 562) (1981); *Swayn's Appeal* (1249), Just. 1/359, m.36; *Paiards's Appeal* (1249?), Just. 1/174, m.40d; *Orscherd's Appeal* (1249?), Just. 1/174, m.40d; *Gundewine's Appeal* (1247), Just. 1/274, m14d; *Phina's Appeal* (1246), Just. 1/778, m.57, summarized in Meekings, *supra* at 267; *Aubyn's Appeal*, The London Eyre of 1244 at 50-51 (no. 124) (London Rec. Soc'y 1970); *Avener's Appeal* (1244), Eyre of 1244 at 36

(footnote continued)

Means wrongly asserted that there were only two cases before 1600 dealing with abortion, and that the courts in both cases indicated doubt about whether abortion was a crime: *R. v. de Bourton*, Y.B. Mich. 1 Edw. 3, f. 23, pl. 28 (K.B. 1327) [*see* Appendix A] (dubbed by Means as *the Twinslayers' Case*); and *R. v. Anonymous*, Fitzherbert, Graunde Abridgement, tit. Corone, f. 268r, pl. 263 (1st ed. 1516) (K.B. 1348) [*see* Appendix B] (dubbed by Means as *the Abortionist's Case).* Means (and the *Roe* majority) relied on a faulty rendering of *R. v. de Bourton* for his analysis. Even if these problems are overlooked, Means' highly partisan analysis contained serious errors as even supporters of his ultimate conclusions have acknowledged.[10]

Even if the faulty text of *R. v. de Bourton* is taken as definitive, at most it, like *R. v. Anonymous*, shows a court declining to prosecute through uncertainty over whether a case was properly before the court, not because of the non-criminality of abortion.[11] In *R. v. de Bourton*, the defendant apparently had been released on bail to answer for another charge, and actually was given a special pardon before trial. In *R. v. Anonymous*, the defendant escaped conviction because the indictment failed to state a baptismal name for the deceased,[12]

Footnote 9 continued

(no. 84); *Modi's Appeal* (1221), 59 Selden Soc'y 560-561 (no. 1336) (1940); *Burel's Appeal* (1202), 1 Selden Soc'y 11 (no. 26) (1887). At least once the proceeding was aborted by the ancient form of benefit of clergy, which precluded trial. *Philippa's Appeal* (1276?), Eyre of 1276 at 51 (no. 187).

[10] *See, e.g.*, Gavigan, *The Criminal Sanction as it Relates to Human Reproduction: the Genesis of the Statutory Prohibition of Abortion*, 5 J. Leg. His. 20, 22-29 (1984).

[11] *See generally* Dellapenna, *supra* note 5, at 368-370; Keown, *supra* note 2, at 4.

[12] This ignores the fact that "murder", at least until 1340, meant a fine imposed on a district when no one could prove a deceased's identity as an Englishman. 1 Holdsworth, *supra* note 8, at 65-77, 580-632; 1 F. Pollock & F. Maitland, *The History of English Law before the Time of Edward I* 67-68, 545 (2d ed, 1898); 2 Pollock & Maitland at 480-486.

and because it was impossible to know if the defendant killed the child—grounds that are procedural and evidentiary, not substantive, grounds.[13] Influential contemporary commentators on the common law also declared abortion of a woman "quick with child" to be a criminal homicide.[14]

After 1500, cases became more common. First, a coroner's inquest ruled that death by abortion was "felonious suicide"; the man involved was released, as an accessory then could not be tried without the principal. *R. v. Lichefeld*, K.B. 27/974, Rex m.4 (1505) [*see* Appendix B].[15] Later, a man died before trial for giving a potion to a girl to induce an abortion. *R. v. Wodlake*, K.B. 9/513/m.23 (1530), K.B. 29/162/m11d (1531).[16] Yet later, a woman was convicted of abortion by witchcraft. *R. v. Turnour*, Assize 35/23/29 (Essex 1581) [*see* Appendix B].[17] Yet another court held that accusing a woman of offering abortifacients to another supported an actin for slander and were sufficient grounds for a court to require a bond for good behavior. *Cockaine v. Witnam* (1577), Cro. Eliz. 49 (1586).

Curiously, two Sixteenth Century authorities on common law criminal pleadings denied that abortion was a felony. 1 W.

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[13] *Cf.* Winfield, *The Unborn Child*, 4 U. Tor. L.J. 278, 280 (1942).

[14] 2 H. Bracton, *On the Laws and Customs of England* 341 (S. Thorne ed. 1968); 1 *Fleta* 60-61 (Selden Soc'y ed. 1955). *Britton* 95-96 (F. Morgen ed. 1901) disagreed—because of the lack of a baptismal name for the victim.

[15] *See also R. v. Robynson*, Q/SR 110/68 (Coroner's Inquest 1589); *R. v. Wynspere*, (Coroner's Inquest 1503), Pub. Rec.Off., ref: Ancient Indictments 434, 12. *See* Keown, *supra* note 2, at 6.

[16] *See also* 2 *Reports of Sir John Spelman* 306 (J. Baker ed.), 94 Selden Soc'y 306 (1978).

[17] Some have said that Turnour was executed for abortion, but as she was convicted of several acts of witchcraft, only one of which was abortion, the record is unclear as to why she was executed; even if abortion were why she died, the crime was witchcraft, and not criminal abortion or homicide as such. *See* Calendar of Assize Rec., Essex Indictments, Eliz. I at 212 (no. 1225) (J. Cockburn ed. 1978).

Staunford, *Pleas of the Crown* ch. 13 (1557); W. Lambard, *Of the Office of the Justice of the Peace* 217-218 (1st ed. 1581). Yet an early formbook, with four editions between 1506 and 1544, included a form indictment for abortion by physical assault on the mother. *Boke of the Justyces of the Peas* c. vi, fol. iii (1515). Perhaps Staunford and Lambard only reflected uncertainty from the poorly reported decisions; or perhaps they meant that abortion was a crime less than a felony; or perhaps they meant that abortion properly belonged before a court other than the Queen's Bench. Three centuries later, Sir John Stephen concluded that they meant that abortion was properly brought only before ecclesiastical courts. 1 J. Stephen, *A History of the Criminal Law of England* 54 (1883). If so, they were wrong.

Some part of the Sixteenth Century legal activity regarding abortion did represent a secularization of matters formerly left to the ecclesiastical domain. Ecclesiastical activity directed at abortion declined during the Reformation,[18] and common law courts took full responsibility for abortion,[19] in a process culminating in a series of decisions in the Seventeenth Century that clearly establish, if the cases already noted did not, that abortion was a serious crime.

In 1601, two Queen's Bench Justices held an abortion which kills a child after a live birth is murder, *R. v. Sims*, 75 Eng. Rep. 1075 (Q.B. 1601) [*see* Appendix B],[20] stating that the birth and

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[18] R. Houlbrooke, *Church Courts and the People during the English Reformation 1520-1570* 78 (1979).

[19] Witchcraft became an indictable crime by the statute of 5 Eliz. I, c.15 (1573); within eight years, we find *R. v. Tournour, supra*.

[20] There were a number of possible precedents for the decision, but *R. v. Sims* seems finally to have settled the matter. *Sims* itself was an action in trespass, which at the time still was a hybrid action combining both criminal and civil elements. For the evolution of medieval trespass into both modern crimes and modern torts, *see* 2 Holdsworth, *supra* note 8, at 364-365; 3 Holdsworth at 317-318, 609-611; 4 Holdsworth at 512-515; 2 Pollock & Maitland, *supra* note 12, at 510-524.

subsequent death of the child permitted proof of the cause of death.[21] In 1602, in *R. v. Webb*, Calendar of Assize Rec., Surray Indictments, Eliz. I 512 (no. 3146) (J. Cockburn ed. 1980) [*see* Appendix B], a woman apparently was convicted and pardoned[22] for self-abortion with rat poison. Finally, in 1670 Sir Matthew Hale held that the death of a mother from an abortion was a felony homicide. *R. v. Anonymous*, M. Hale, *History of Pleas of the Crown* 429-430 (1685).[23]

R. v. Sims was argued before the court by Attorney-General Sir Edward Coke (the "Father of the Common Law"). In his *Third Institute* 50-51 (1644), Coke generalized a principle from the case that abortion after quickening was "a great misprision [a serious misdemeanor], and no murder" if the child died in the womb, and a murder if the child died after birth. Coke's position thereafter was accepted virtually without question.[24]

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[21] For the primitive state of forensic medicine nearly three centuries later, *see* Forbes, *Early Forensic Medicine in England: the Angus Murder Trial*, 36 J. Hist. Med. 296 (1981).

[22] *See* note 4 *supra*.

[23] For other Seventeenth Century indictments without record of the outcome, *see Commonwealth v. Simpson* (1659), 6 N. Riding Q. Sess. Rec. 23 (J. Atkinson ed. 1888); *Commonwealth v. Forall* (1651), 3 Warwick Cnty. Rec., Q. Sess. Order Book 50 (S. Ratcliff & H. Johnson eds. 1937); *R. v. Hodges* (1615), 2 Calendar of Middlesex Cnty. Sess. Rec. 1614-1615 at 345 (1936).

[24] 1 W. Blackstone, *Commentaries* 129-130 (1765); 4 Blackstone 198 (1769); R. Burn, *The Justice of the Peace and the Parish Officer* 380 (3d ed. 1756); 1 E. East, *A Treatise on the Pleas of the Crown* 227-230 (1803); M. Hale, *Pleas of the Crown* 53 (1682); 2 W. Hawkins, *Treatise on the Pleas of the Crown* 80 (1716); 1 W. Russell, *A Treatise on Crimes and Misdemeanors* 617-618, 796 (1819). Two books are attributed to Hale. The one cited here echoed Coke's views; a later book, Hale, *supra* note 8, at 433, denied that an abortion-induced death of a child born alive is a homicide. Which view truly represents Hale's opinion is not known. Courts cited Coke with approval in a variety of contexts, and did not follow the second Hale dictum. *See Millar v. Turner*, 1 Vessey 86 (K.B. 1748); *Beale v. Beale*, 24 Eng. Rep. 373 (K.B. 1713); Keown, *supra* note 2, at 10-11. *See generally* Dellapenna, *supra* note 5, at 379-389.

Coke cited only the inconclusive precedents of *R. v. de Bourton*, *supra*, and *R. v. Anonymous*, *supra*, for his views.[25] Hale cited no precedents at all for his holding.[26] Means dismissed Coke's statement on abortion as a "masterpiece of perversion",[27] yet found Hale's decision on the death of the mother to be "an act of Restoration gallantry".[28] Means did not indicate how to recognize the difference.

By the early Eighteenth Century, the criminality of abortion under the common law appears well established. Courts had given increasingly clear holdings that some abortions were crimes; there was no decision indicating that any form of abortion was lawful. Secondary authorities, especially after 1600, equally supported the criminality of abortion. Yet few cases recorded punishment for any abortion, and none recorded punishment for a voluntary abortion without *either* death for the mother *or* death subsequent to live birth for the child.

B. From Earliest Times, English Law Prohibited Parents from Killing Unwanted Children, and Parliament and the Courts Took Strong Steps, Gradually Strengthened through the Centuries, to Punish Violations of These Prohibitions

The great majority of the cases thus far noted involved crude physical batterings of the mother—often to her serious injury

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[25] *Cf. R. v. Portere* (K.B. 1400), The Shropshire Peace Role 1400-1414 57-58 (no. 24) (E. Kimball ed. 1959).

[26] Hale might have cited, *R. v. Adkyns* (1600), Calendar of Assize Rec., Essex Indictments, Eliz. I at 510 (no. 3054) (J. Cockburn ed. 1975); *R. v. Meadow* (1590), Calendar of Assize Rec., Sussex Indictments, Eliz. I at 233 (no. 1212) (J. Cockburn ed. 1975); *R. v. Poope* (1589), Calendar of Assize Rec., Kent Indictments, Eliz. I at 289 (no. 1751) (J. Cockburn ed. 1975). *See also Philippa's Appeal* (1276?), London Eyre of 1276 at 51 (no. 187) (London Rec. Soc'y 1976) (defendant escaped trial due to benefit of clergy); *Orscherd's Appeal* (1249?), Just. 1/174, m.40d (not guilty).

[27] Means II, *supra* note 6, at 359. His view apparently was accepted by the majority in *Roe v. Wade*, 410 U.S. at 135 n.26.

[28] Means II, *supra* note 6, at 363.

or death (injury techniques).[29] The remaining abortions were induced by "noxious potions"—potions that appear to have been nearly as deadly as the batterings (ingestion techniques).[30] From these facts, one might infer that the law was directed at protecting the mother's life or health—if one assumes, as Means, Mohr,[31] and numerous others do, that abortion was always freely available through reasonably safe means.

Both the ingestion and injury techniques found in the legal cases could be effective only with great pain and substantial risk of death or permanent injury; undergoing either cannot have been popular.[32] In fact, voluntary abortions are almost

[29] Injury techniques ranged from ineffective simple bodily manoeuvres up to savage assaults, such as cutting her open and removing the infant.

[30] Appeals or indictments for abortion by potion might have been rarer than for abortion by assault because a potion often was part of a magic ritual punishable as witchcraft even if ineffective, but only by an ecclesiastical court before Elizabeth I. Among medically primitive cultures, anthropologists have found injury techniques to be most common, if only because of the greater certainty of success. G. Devereux, *A Study of Abortion in Primitive Societies* 30-35, 171-358 (1955). *See also* J. Bates & E. Zawadski, *Criminal Abortion* 87-88 (1964); A. McLaren, *Reproductive Rituals* 100-108 (1984); F. Taussig, *Abortion Spontaneous and Induced* 41-45 (1936).

[31] Mohr, *supra* note 7, at 6-19, listed methods he assumed to be safe and effective, which was unfounded—even he acknowledged the poisonous nature of some of his "abortifacients". *Id.* at 71-73. E. Shorter, *A History of Women's Bodies* 177-191 (1982), also assumed that workable techniques existed, although he admitted that his own catalogue included only the useless or the fatal. Other historians have made the same assumption on even less evidence, A. Eccles, *Obstetrics and Gynaecology in Tudor and Stuart England* 67 (1982); McLaren, *supra* note 30, at 5-7, 107, 111-114; G. Quaife, *Wanton Wenches and Wayward Wives* 118-120 (1979); C. Smith-Rosenberg, *Disorderly Conduct* 228 (1985). Compare the text and notes at notes 34-38 *infra*.

[32] *Even Shorter, supra* note 31, at 177, concluded that until after 1880 only truly desperate women would risk abortion. Quaife, *supra* note 31, at 26, describes injury techniques in connection with his analysis of violence, and not with his analysis of abortion, while he concedes that women were rarely anxious to use ingestion techniques. *Supra* at 118.

absent from reported cases before 1732[33] for a simple reason: techniques of the time were tantamount to suicide.[34] Thus abortion which was not a crime against the mother was rare.[35]

The unpopularity of injury techniques hardly needs demonstration. While we cannot know all potions available in medieval England, surveys of the medical literature there and in other medically primitive societies demonstrate that the potions ingested to induce an abortion were either ineffective (except for any suggestive powers to which a woman might be susceptible) or highly dangerous.[36] Savin oil was the "abortifacient" most widely reported in medieval English sources. Modern research demonstrates that it works by undermining a

[33] The only apparently voluntary abortions reported were *R. v. Wynspere*, *supra* note 12, and *R. v. Webb*, *supra* note 22. In some cases, assertions that a potion was given by trick, etc., might have been dissimulation by the mother; this seems unlikely in the numerous cases of aborton by savage physical attack.

[34] Devereux, *supra* note 30, at 149-150. *See generally* Dellapenna, *supra* note 5, at 372-376, 393-395.

[35] One attempt at a study of the incidence of abortion in the early modern period, based on searching church records (which do not distinguish between spontaneous and induced abortions), P. Laslett, *The World We Have Lost* 123 (1966), found abortions in Seventeenth Century England to amount to 6-7% of total births. As in the Twentieth Century spontaneous abortions range from 7.5-11% with our more advanced medical technology, *id.* at 266, the Seventeenth Century figures reveal few, if any, induced abortions.

[36] Bates & Zawadski, *supra* note 30, at 14-23, 85-91; Devereux, *supra* note 30, at 36-43, 249, 279; N. Himes, *Medical History of Contraception* 139-151 (1936); J. Noonan, *Contraception* 222-230 (1965); Shorter, *supra* note 31, at 179-188; Taussig, *supra* note 30, at 31-45, 352-357; Dellapenna, *supra* note 5, at 373-376. Examples of ineffective "abortifacients" available in England include goat dung, raw eggs, hops, "ungrateful strong smells", and wine. Drugs the ingestion of which in massively dangerous quantities could bring on a abortion included caster oil, ergot of rye, hellebore, pennyroyal, rue, savin oil (juniper), tansy tea, thyme, and yarrow. Finally, a sufficiently desperate woman could ingest (or be made to ingest) a substance lethal even in small quantities, such as aloes, arsenic, "ratsbane" (rat poison), snake venom, and various metallic salts.

woman's health generally so she could not sustain pregnancy, all too often to the point of death.[37] The dangers of these "abortifacient potions" were so great that in early English slang the term "poisoned" meant pregnant![38]

One cannot entirely rule out the possibility of a safe and effective drug escaping notice in the legal, medical, and popular literature of the day. Yet the Arabic medical texts which, upon translation into Latin, were standard medical references in the later middle ages described nothing more safe and effective than the potions listed here.[39] Nor do later works in English add anything significant.[40] Given the general limited inventiveness of pre-scientific societies, one also must not be surprised at the lack of variation in abortion techniques over six centuries.

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[37] One modern study found that savin oil did induce an abortion in 10 of 21 women who consumed it: nine of the 10 "successful" ones died, as did four of the "unsuccessful" ones. Taussig, *supra* note 30, at 353. In fact, most modern poisons were discovered through vain searches for a safe dosage of "abortifacients". Bates & Zawadski, *supra* note 30, at 88. For a graphic description of a savin death, *see* Forbes, *supra* note 21. *See generally* Shorter, *supra* note 31, at 186-188.

[38] F. Grose, *A Classical Dictionary of the Vulgar Tongue* (1785); McLaren, *supra* note 30, at 102. Yet another historian, who optimistically presumes that knowledge of safe and effective abortifacients was widespread, also notes that lead-poisoning was "epidemic" because of the use of the abortifacients. J. Weeks, *Sex, Politics and Society* 72 (1981). Even Mohr, *supra* note 7, at 71-73, notes that savin poisoning was widespread from abortion.

[39] Avicenna, *Libri Canonis Medicine* (Gerard of Cremona trans. 1595); Rhazes, *Liber ad Almansorem* (1497). *See also* Himes, *supra* note 36, at 139-151.

[40] 1 *Compleat Herbal* 69-71, 94-95 (G. Swindells ed. 1787); M. Etmullerus, *Description of All Diseases Incident to Men, Women and Children* 563 (3d ed. 1712); J. Pechey, *Compleat Herbal of Physical Plants* 13 (1707). These and other texts describe "abortifacient" effects in language markedly different from the descriptions of other pharmacological effects. "Abortifacient" effects are always introduced with phrases suchas "it is said", suggesting either uncertainty about the efficacy of the potion or unwillingness to be thought to favor the practice. McLaren, *supra* note 30, at 102-104, 123; Noonan, *supra* note 36, at 201-207, 217.

Singularly lacking from the literature is any mention of "intrusion techniques"—techniques using an intrusion through the cervix into the uterus to induce abortion.[41] Given the primitive knowledge of a woman's reproductive anatomy,[42] intrusive intervention can rarely have been successful. The closest one finds to an intrusion technique are occasional mentions of a "pessary"—the insertion of a vaginal suppository, usually laced with "abortifacient drugs", that did not penetrate the cervix. Without such penetration, however, pessaries do not seem to have been effective.[43]

Many still persist in believing that medically primitive cultures, including medieval England and colonial America, had mysterious abortion techniques that were safe, effective, and perhaps relatively painless. If so, why would simple, safe, and effective folk medicines abruptly disappear in the Nineteenth Century to be replaced by the highly dangerous intrusion techniques that supposedly then made abortion so dangerous as to justify the widespread adoption of statutes proscribing abortion? The true explanation was expressed by Mary Kenny: before the Nineteenth Century, "[t]he traditional forms of abortion had been infanticide and abandonment."[44]

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[41] Even Shorter, *supra* note 31, at 188-191, concedes that instrumental (intrusion) abortions were not a realistic possibility before the Nineteenth Century. *See also* Devereux, *supra* note 30, at 28, 36-37.

[42] Consider contemporary views of how such potions functioned. Not only were potions often given in a belief that a woman had blocked menses rather than pregnancy, but the potions were sometimes given to prevent a woman's uterus from rising to her throat to choke her! Shorter, *supra* note 31, at 180, 286-287.

[43] Devereux, *supra* note 30, at 37; McLaren, *supra* note 30, at 101-102; Taussig, *supra* note 30, at 355-356. The ineffectiveness of pessaries did not prevent doctors from swearing a Hippocratic Oath not to administer them, at least as the oath was before it was amended after *Roe v. Wade*. A. Castiglioni, *A History of Medicine* 148 (2d ed. 1947).

[44] M. Kenny, *Abortion: the Whole Story* 181 (1986).

Infanticide was a crime under the early common law;[45] Parliament reacted to its frequent occurrence[46] by enacting ever stronger statutes prohibiting the practice. The royal courts also actively punished those found guilty of the crime.[47] All this occurred when both the incidence of true abortion and legal activity regarding it were still rare.

The stringency of the law of infanticide is shown by *R. v. Parker*, 73 Eng. Rep. 410 (1580), where even benefit of clergy was denied and a clergyman was executed for the crime. The earliest regulations of midwives (1512) were to prevent the killing of infants.[48] The tightening of the law against infanticide culminated in "An Act to Prevent the Destroying and Murdering of Bastard Children", 21 James 1, ch. 27, sec. 3 (1624), which conclusively presumed murder from concealment of the death of a child in order to conceal its birth.

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[45] Infanticide was a crime in Anglo-Saxon law. J. Thrupp, *The Anglo-Saxon Home* 85 (1862). At least one early book (ca. 1300) states that infanticide within one year of birth was cognizable only by ecclesiastical courts. *Mirror of Justices* 139 (Selden Soc'y 1895). 2 Pollock & Maitland, *supra* note 4, at 478 n.1, dismissed this book as worthless. Staunford, *supra*, at ch. 13, and Lambarde, *supra*, at 217-218, cited a 1315 conviction as indicating that infanticide was a common law felony (in the same passages where they apparently denied that abortion was a common law felony).

[46] Dead babies were a common sight in London streets well into the Nineteenth Century. Rolph, *A Backward Glance at the Age of 'Obscenity'*, *32 Encounter 23 (June 1969)*. *See also* D. Bakan, *The Slaughter of the Innocents* (1971); J. Boswell, *The Kindness of Others: the Abandonment of Children in Western Europe from Late Antiquity to the Renaissance* (1989); M. Piers, *Infanticide: Past and Present* (1974); Dellapenna, *supra* note 5, at 395-400; Helmholz, *supra* note 8.

[47] P. Hoffer & N. Hull, *Murdering Mothers: Infanticide in England and New England 1558-1803* (1984).

[48] J. Donnison, *Midwives and Medical Men* 18-20 (1988). These regulations were repeatedly strengthened. T. Forbes, *The Midwife and the Witch* 144-147 (1966). Wet-nurses as well as midwives could have been characterized as major population control arrangements. J. Guillemeau, *The Nursing of Children*, preface (1612). *See generally* Dellapenna, *supra* note 5, at 396-397.

Only the emergency of abortion as a real alternative to infanticide brought a decline in the incidence of infanticide and the legal attention to it. The intimate relationship between abortion and infanticide was demonstrated by the fact that the next section of Lord Ellenborough's Act after the first English statutory prohibition of abortion reduced the penalty for concealment from death to a term of imprisonment. 43 Geo. 3 c.58, secs. 2-4 (1803).[49]

C. Early in the Colonial Period, These Laws Were Received with Full Rigor in the United States

The colonists from England brought the common law with them. In just one colony, no less than three prosecutions for criminal abortion arose before 1664: *Proprietary v. Lambrozo*, 53 Md. Archives 387-391 (1663); *Proprietary v. Brooks*, 10 Md. Archives 464-465, 486-488 (1656); *Proprietary v. Mitchell*, 10 Md. Archives 171-186 (1652) [*see* Appendix B].[50] In two of these cases, the defendant escaped conviction by, before trial, marrying (and thereby disqualifying) the principal witness against him. Mitchell was indicted for and convicted of attempted murder, apparently because the prosecutor could not prove the cause of the death of the stillborn child.

Other colonial prosecutions for abortion arose at similar early dates. In Rhode Island, a woman was given 15 lashes for fornication and attempted abortion. *Colony v. Allen*, Newport Cnty. Gen. Ct. Trials: 1671-1724A n.p. (Sept. 4, 1683 sess.).[51] Other charges of abortion through violent physical assaults are recorded without indication of the outcome. *In re the Stillbirth of Agnita Hendricks' Bastard Child* (Del. 1679), Ct. Rec. of New Castle on Del. 1676-1681 at 274-275 (1904); *Colony v.*

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[49] For the legislative history, *see Keown*, *supra* note 2, at 12-21.

[50] *See also Proprietary v. Robins*, 41 Md. Archives 20 (1658), and *Robins v. Robins*, 41 Md. Archives 85 (1658).

[51] Noted in L. Koehler, *A Search for Power: the "Weaker Sex" in Seventeenth-Century New England* 329, 336 n. 132 (1980).

Powell (Va. 1635), 7 Am. L. Rec. 43 (1954). Finally, a 1716 municipal ordinance in New York forbade midwives to aid or counsel abortion. 3 Min. of the Common Council of N.Y. 122.[52] Abortion simply was never accepted in American society, contrary to the bald assertions of Means, Mohr, and others; nor is there any reason to believe that abortion was more readily available, or more frequently practiced, in the colonies than in England.[53]

Infanticide in the colonies had considerable legal activity against it.[54] The close empirical link of the concealment statutes and abortion was again demonstrated by 11 states which enacted a concealment statute contemporaneously with the state's first abortion statute, while 20 states codified the two statutes together.[55] Thus, from earliest times, colonial society prohibited the murder of an unwanted child by its parents, whether by abortion or by infanticide.

[52] M. Gordon, *Aesculapius Comes to the Colonies: the Story of the Early Days of Medicine in the Thirteen Original Colonies* 174-175 (1949). For reference to a similar ordinance in Virginia, *see* S. Massengill, *A Sketch of Medicine and Pharmacy* 294 (2d ed. 1942).

[53] C. Scholten, *Childbearing in American Society 1650-1850* 9 (1985).

[54] Hoffer & Hull, *supra* note 47, at 33-113. Statutes were enacted to punish concealment—of either the birth or the death of a child—as murder in eight colonies or states before they adopted an abortion statute, beginning with Massachusetts in 1696. *Charters & Gen'l L. of the Colony & Prov. of Mass. Bay* 293 (Dane, Prescott, & Story eds. 1814). There was at least one prosecution for concealment even before a colonial statute was adopted. 2 J. Winthrop, *History of New England 1630-1649* 317-318 (Hosmer ed. 1908). Even the Salem Witchcraft Trials have been linked to infanticide. Hoffer & Hull, *supra* at 55-56.

[55] Dellapenna, *supra* note 5, at 399.

D. When Abortion Became More Common than Infanticide with the Development of Technical Means for Aborting a Woman with a Lessened Danger to Her Life, English and American Law Came to Emphasize Abortion as the Primary Evil

The dramatic introduction of abortion statutes throughout the English speaking world in the Nineteenth Century has been amply documented.[56] The majority in *Roe v. Wade* viewed this development, and the similarly dramatic increase in prosecutions, as a result of Victorian sexual attitudes, fears for maternal health, and concern for the life of the unborn child. 410 U.S. at 147-152. The majority offered no explanation why these reasons became weighty only in the Nineteenth Century.

Means insisted that only the second reason applied.[57] He also did not attempt to explain why fear for maternal health should have come to the fore then and not earlier. Mohr, while recognizing distress over falling birthrates among the middle and upper classes and over a "moral prejudice" favoring the life of unborn children,[58] argued that the real reason was to assure the dominance of the newly organized American Medical Association over its less qualified competitors, especially midwives.[59] He did not explain why these concerns should have won public support, a glaring omission as he insisted that the public supported free availability for abortions. Thus, such

[56] *See* note 5 *supra*. This process occurred throughout most of the world during the same time. Kenny, *supra* note 44, at 183.

[57] Means I, *supra* note 6, at 511-515; Means II, *supra* note 6, at 382-392.

[58] Mohr, *supra* note 7, at 35-36, 85-118, 128, 167-168, 175-176, 182-196.

[59] *Id.* at 32-37, 147-182. *See also* M. Walsh, *Doctors Wanted: No Women Need Apply* (1977). Mohr discounted concern for maternal health because he believed that abortion was safe. *Id.* at 25-40. A similar argument, made across a much broader front, appears in P. Starr, *The Social Transformation of American Medicine* (1982). For a critique of Starr's neglect of the role of technological change in transforming medicine, *see* Brandt, *The Ways and Means of American Medicine*, Hastings Cntr. Rep., June 1983, at 41.

views simply beg the question of why abortion suddenly became a subject of significant legal and social concern in the Nineteenth Century, and seriously misconceive the legal, medical, and social import of the abortion statutes.

Voluntary surgery has nearly always been treated as a private matter between a patient and an attending physician. Until *Roe v. Wade*, voluntary abortion simply was not treated as such a private matter. For example, in 1828 the New York legislature rejected a proposal to ban all surgery unless "necessary for the preservation of life", but accepted another part of the same proposal declaring abortion a crime.[60] This difference is rooted in technological change and social values.

The technological change was the introduction of intrusion techniques in England in the early Eighteenth Century.[61] The new technique first turned up in a legal case when a woman was sentenced to be pilloried and to serve three years in prison for aborting another woman, before quickening, by inserting an iron rod into the second woman's womb. *R. v. Beare*, 2 The Gentleman's Magazine 931 (Aug. 1732) [*see* Appendix B]. The report of the case is striking for the strong shock the event provoked in the Queen's Counsel and the court. They decry the incident as "barbarous" and "unnatural", particularly mentioning the manner used to induce the abortion, suggesting a novelty unlikely if such techniques where part of the common fund of knowledge of folk medicine at the time. Note also that the case involved an apparently voluntary abortion with no reported lasting ill effects for the mother.

Convictions are reported in similar cases in rather rapid order. *R. v. Tinckler* (1781), 1 E. East, *Pleas of the Crown* 354-356 (1806) [*see* Apendix B]; *R. v. Anonymous*, 3 J. Chitty, *Criminal Law* 798-801 (1816). Such abortions, however,

[60] Means I, *supra* note 6, at 451.

[61] Shorter, *supra* note 31, at 188-208, places the invention of effective intrusion techniques as late in the Nineteenth Century. *See also* M. Potts, P. Diggory & J. Peel, *Abortion* 170-188 (1977).

remained highly dangerous: Margaret Tinckler was convicted of murder of the mother. Inserted objects became a highway to infection that could cause loss of the uterus or death, and was sufficiently painful (especially if the uterine wall was pierced) to induce life-threatening shock.[62]

Dangerous and painful as these procedures were, death was not as certain as with the injury and ingestion techniques. Intrusion techniques quickly became the technique of choice, setting the stage for the surgical and other intrusion techniques that account for most abortions performed today. Lord Ellenborough himself seemed to reflect the resulting sudden upsurge in abortions in the preamble to his famous Act: it concerned "certain . . . heinous offenses . . . of late also frequently committed . . ." 43 Geo. III, c. 58. At this time fears of a threat to the health of the mother from voluntary abortion also appear for the first time in the legal and medical literature.[63]

Both England and the American states undertook to codify their criminal law beginning early in the Nineteenth Century. The earliest statutory prohibitions of abortion were part of that process, as was true of Lord Ellenborough's Act, *supra*,[64] and of the New York proposals, *supra*, to regulate abortion and other surgeries. That abortion statutes were part of the codification process suggests an intent to restate the law of abor-

[62] Bates & Zawadski, *supra* note 30, at 85-87. Apparently abortions killed one-third of the women undergoing them early in the Nineteenth Century. Dellapenna, *supra* note 5, at 400, 412.

[63] O. Bartley, *A Treatise on Forensic Medicine* 3, 5 (1815); J. Burns, *The Anatomy of the Gravid Uterus* 57-58 (1799); 1 East, *supra* note 24, at 230; G. Male, *An Epitome of Judicial or Forensic Medicine* 116-117 (1816); A. Taylor, *Manual of Medical Jurisprudence* 595 (1842). *See also State v. Murphy*, 27 N.J.L. 112, 114-115 (1858). *See generally* Keown, *supra* note 2, at 35-38.

[64] Officially styled the "Offenses against the Person Act", the first comprehensive such English statute in English law. *See* 11 *Holdsworth*, *supra* note 8, at 537.

tion, not to change it, particularly when as in New York, proposals to change the law were rejected.

The New York proposals of 1828 highlight other dimensions of the process of codifying the law of abortion. All surgery was highly dangerous for the same reasons as intrusive abortions: infection and shock. Only for abortion were social pressures likely to induce one to undergo the procedure without prior risk to life or limb. Thus aborton statutes could be seen as a response to premature application of new medical technology.[65] The statutes, which quickly broadened their reach to all kinds of abortion at all stages of pregnancy, served to indicate that intrusive abortions were as criminal as abortions by injury or ingestion techniques. The statutes also settled the somewhat uncertain law governing abortion[66] (the very uncertainty of which suggests that the procedure was not something commonly encountered), and perhaps solemnly reaffirmed social policy in the face of changing social behavior.

The broadening of the statutes to all stages of pregnancy suggests the second major motivation behind the Nineteenth Century abortion statutes: protection of the life of the foetus. Many courts expressed this as the major purpose of the abortion statutes. *Dougherty v. People*, 1 Colo. 514 (1872); *State v. Moore*, 25 Iowa 128 (1868); *People v. Sessions*, 58 Mich. 594, 26 N.W. 291 (1886); *State v. Gedicke*, 43 N.J.L. 86 (1881); *State v. Crook*, 16 Utah 212, 51 P. 1091 (1898); *State v. Howard*, 32 Vt. 380 (1859). Medical and religious leaders also supported this

[65] *See generally* Keown, *supra* note 2, at 12-48.

[66] Note the split in the Nineteenth Century American cases over whether abortion before quickening was a crime at common law: *Mitchell v. Commonwealth*, 78 Ky. 204 (1879) (no crime); *Lamb v. State*, 67 Md. 524, 10 A. 208 (1887) (crime); *Commonwealth v. Parker*, 50 Mass. (9 Met.) 263 (1845) (no crime); *Commonwealth v. Bangs*, 9 Mass. 387 (1812) (no crime); *Mills v. Commonwealth*, 13 Pa. 630 (1850) (crime).

view.[67] Unless one believes, as Mohr argued, that these were insincere ruses to hide less noble motives, one must concede that protection of unborn children from a rising number of abortions was at least as significant a motive for the Nineteenth Century abortion statutes as protection of the life of the mother.

II. *Roe v. Wade* Should Be Overruled and the Resolution of the Competing Claims of Mothers and Their Offspring Should Be Returned to the Legislative Branches of Government

The abortion problem, a result of the intersection of policies protecting mothers and unborn children with changing medical technology, requires balancing the claims of mother and child that is best left to legislative development rather than dictation by courts. Consider the analysis of the late Professor Alexander Bickel of the trimester scheme from *Roe v. Wade:*

> "One is left to ask why. The Court never said. It refused the discipline to which its function is properly subject. It simply asserted the result it reached. If medical considerations only were involved, a satisfactory rational answer might be arrived at. But, as the Court acknowledged, they are not. Should not the question then have been left to the political process, which in state after state can achieve not one but many accommodations, adjusting them from time to time as attitudes change?"[68]

A. Changes in Medical Technology Are Central to a Proper Resolution of the Controversies over Abortion

At all times, evolving medical technologies of abortion and of recognition of, and care for, an individual unborn child, have

[67] The majority in *Roe v. Wade*, 410 U.S. at 141-142, quoted representative samplings of such statements. *See also* Mohr, *supra* note 7, at 35-36, 175-176, 182-196. *See also* notes 59 & 60 *supra*.

[68] A. Bickel, *The Morality of Consent* 28 (1975). *See also Roe v. Wade*, 410 U.S. at 219-223 (Rehnquist & White, JJ., dissenting).

shaped the interests feeding the abortion controversy. Until the Twentieth Century, both resulting interests converged on criminalizing abortion. Now those interests have diverged, bringing controversy to an area where once all agreed that only evil could be found.[69]

Technical progress did not end with a crude insertion device. Modern medical techniques, basic general surgical advances, have further reduced the pain of, and the danger of uterine injury from, an abortion, making the procedure physically safe for the mother. Pain-killing drugs (beginning with morphine in 1806), anesthesia from the 1840's, antiseptics after 1867, and finally sulfa drugs in the 1930's and antibiotics (beginning with penicillin in 1940) have dramatically reduced the risk of death or injury through shock or infection. Many women thus came to see the abortion's prohibition, rather than its possibility, as the threat to their well-being.[70]

Yet the perceived interests of society in unborn children also changed with new medical technologies of human reproduction, shown by the demise of the ancient distinction of "quickening".[71] With the application of cell theory to embryology at the opening of the Nineteenth Century, a revolution in our understanding of human reproduction occurred.[72] Opinion leaders in all areas of society quickly concluded that a new human life began at conception, and not at quickening.[73] The

[69] Even Margaret Sanger, founder of Planned Parenthood, initially condemned abortion. M. Sanger, *Motherhood in Bondage* 394-396 (1928).

[70] *See generally* Dellapenna, *supra* note 5, at 411-414; Potts, Diggory & Peal, *supra* note 61, at 170-188; Shorter, *supra* note 31, at 191-224.

[71] A distinction in English law at least as early as Bracton. *Supra* note 14, at 341.

[72] *See generally* 3 *A History of Science* 456-483 (R. Taton ed. 1965); A. Meyer, *The Rise of Embryology* 28-120, 138-147, 170-194, 302-341 (1939); J. Needham, *A History of Embryology* 115-229 (1959).

[73] *Roe v. Wade*, 410 U.S. at 141-142; D. Callahan, *Abortion: Law, Choice and Morality* 410-461 (1970); Mohr, *supra* note 7, at 35-36, 175-176, 182-196.

adoption of abortion statutes removing any distinction based on quickening[74] highlight that the statutes were crafted to protect human life. In a different context (staying the execution of a pregnant woman), an English court also interpreted the statutory term "quickening" to mean conception, rather than a felt movement of the child within the womb, reflecting again a change in the concept of when human life begins. *R. v. Wycherley*, 173 Eng. Rep. 486 (N.P. 1838).

Today an embryologist or fetologist can diagnose and treat an unborn child independently of its mother, including removing the child from the womb for surgery and returning it to the womb to complete gestation. Such physicians can hardly continue to consider the child a mere extension of its mother, a fact strikingly demonstated by the odyssey of Dr. Bernard Nathanson from "Abortion King" of New York to anti-abortion activist.[75] For one not impressed by claims of fetal personhood, continuing prohibition of abortion in the face of the increasing safety of the procedure for mothers can only seem a serious intrusion into the liberty of women because of "moral prejudice".[76] This view ignores the unbroken tradition of the common law of protecting an unwanted child from aggression by its parents.

Reproductive technology continues to advance rapidly. The majority in *Roe v. Wade* and *Doe v. Bolton* clearly was deeply

[74] The first was the Offenses against the Persons Act, 7 Will. 4 & 1 Vict., c. 85 (1837). Illinois had already removed the quickening distinction, but only for abortions by a "noxious substance", Ill. Rev. Code sec. 46 (1827), perhaps suggesting a concern to protect the mother and not the child. Maine adopted the first American statute to remove all distinctions based on quickening, Me. Rev. Stat., ch. 160, secs. 13, 14 (1840).

[75] B. Nathanson, *Aborting America* (1979); B. Nathanson, *The Abortion Papers* (1983). *See generally* Dellapenna, *supra* note 5, at 414-416.

[76] *See Doe v. Bolton*, 410 U.S. 179, 193-194, 197-198, 199 (1973), where the majority stressed repeatedly that there was "no reason" to treat abortion differently from other minor surgery.

concerned about physicians' autonomy.[77] Without denying the necessary impact of professional opinion on these questions, and recognizing the virtue of professional autonomy if advances all want are to continue, the law still cannot be fashioned solely to protect the autonomy of the technicians as the issues concerning abortion transcend mere technical competence.

The abortion controversy involves balancing interests and values created or reinforced by changing medical technologies. In all areas of medical practice, except abortion, states have broad authority to regulate acts by physicians. Even for abortion, the social community, not individual physicians, should be the final arbiter of the propriety of conduct. *Simopolous v. Virginia*, 462 U.S. 506 (1983).

B. Legislatures Are Best Placed to Explore Appropriate Regulatory Responses to Changing Reproductive Technologies

The central problem in this controversy is which institution of government is charged by the Constitution to balance the competing interests and values in the abortion controversy.[78] As Justice Stevens argued in his concurring opinion to *City of Richmond v. J.A. Croson Co.*, 109 S. Ct. 706, 731-732 (1989), legislatures are better suited to establishing policies for the future, leaving to courts primary responsibility for fashioning remedies for past wrongs. Why should this not apply to abortion? Lacking the tools of inquiry of a legislature, the Court is

[77] *See* particularly *Doe v. Bolton*, where the majority accorded doctors standing as a class, 410 U.S. at 188-189, and the majority repeatedly adverted to the doctors' privacy interest. *Id.* at 192-193, 196-201. Although the majority denied standing to a specific doctor in *Roe v. Wade*, 410 U.S. at 125-127, they repeatedly referred to medical opinions, *id.* at 130-132, 141-146, 149-150, 159, 163, and they finally gave the physician decision-making power equal to the mother. *Id.* at 153, 162-166. *See also Thornburgh v. American College of Obstetricians*, 476 U.S. 747, 759-765 (1986); *Colautti v. Franklin*, 439 U.S. 379 (1979).

[78] *Cf.* A. Bickel, *The Least Dangerous Branch* 142 (1962).

simply not suited to serve as a board of review for the impacts of medical technology. *City of Akron*, *supra*, at 454-459 (O'Connor, dissenting). Yet, ever since *Roe v. Wade* was decided, the Court has confronted a series of challenges to abortion regulations requiring the Court to devise correct policies in response to difficult questions of technical fitness and social acceptability.[79]

The majority in *Roe v. Wade* itself recognized its inability to deal with the issues at stake when it was unable to decide when a "person" begins. 410 U.S. at 160. Furthermore, these issues require the government to answer difficult questions involving a balancing of interests rather than the application of neutral principles accepted by nearly all in our society.[80]

Legislatures are best equipped to acquire and update the necessary information to assess the import of changing technologies that create or reinforce interests to be balanced in resolving the resulting controversies. Legislatures are also better equipped to strike a balance through their representative nature.[81] Women are not an insular minority whose interests are any longer likely to be slighted by a legislature.[82] Nor need physicians fear such a legislative process. Legislatures consistently have been sensitive to the interests of the

[79] *Thornburgh v. American College of Obstetricians*, 476 U.S. 747 (1986); *Simopolous v. Virginia*, 462 U.S. 506 (1983); *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476 (1983); *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983); *Harris v. McRae*, 448 U.S. 297 (1980); *Colautti v. Franklin*, 439 U.S. 379 (1979); *Bellotti v. Baird*, 428 U.S. 132 (1976); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52 (1976); *Doe v. Bolton*, 410 U.S. 179 (1973).

[80] *Cf.* A. Cox, *The Role of the Supreme Court in American Government* 113-114 (1976); Ely, *The Wages of Crying Wolf*, 82 Yale L.J. 920, 949 (1973).

[81] *Cf.* R. Dworkin, *Taking Rights Seriously* 22-28 (1976); Wellington, *Common Law Rules and Constitutional Double Standards: Some Notes on Adjudication*, 83 Yale L.J. 221, 297-310 (1973).

[82] *United States v. Carolene Prod. Co.*, 304 U.S. 144, 152 n.4 (1938).

organized medical profession in regulating abortion.[83] There is no reason to expect this to change.

Finally, as Justice Brandeis argued in his dissent to *New State Ice Co. v. Liebman*, 285 U.S. 262, 309-311 (1932), to define federalism in terms of the states as great laboratories for social experiment is one of the best models for approaching questions of whether to preempt state competence. As this Court unanimously affirmed in *Addington v. Texas*, 441 U.S. 418, 431 (1979), the right of states to develop a variety of solutions, consistent with constitutionally-mandated minimum standards, is "the essence of federalism". In an area where the facts change faster than judicial procedures can cope with the resulting issues,[84] courts should defer to the state legislatures as better able to explore regulatory responses to the ensuing problems.

C. If *Roe v. Wade* Is to Continue to Survive in Some Form, the Court Must Continually Reexamine, as It Did in *Webster v. Reproductive Health Services*, the Application of the *Roe* Criteria in Light of New Medical Technology

Justice O'Connor pointed out in her dissent to *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 454-459 (1983), that if *Roe v. Wade* is to continue as the basis of the law of abortion, it is a decision "on a collision course with itself". *Id.* at 456. To avoid contradicting the values announced in *Roe v. Wade*, the Court must reconsider the rules laid down in, or inferred from, the decision. The Court has begun this process in *Webster v. Reproductive Health Services*, 109 S. Ct.

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[83] The sway of the organized physicians over legislatures was the theme of such books as B. Brookes, *Abortion in England 1900-1967* (1968); Donnison, *supra* note 48; Keown, *supra* note 2; Mohr, *supra* note 7; Starr, *supra* note 59; Walsh, *supra* note 59.

[84] *Cf. Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 75-79, 93-99 (White, J., dissenting, with Burger, C.J., & Rehnquist, J.), 101-102 (1976) (Stevens, J., concurring).

3040 (1989). At the very least, if the Court refuses to completely reconsider *Roe v. Wade*, a correct understanding of the history of abortion and the impact of changing medical technology on that history must inform the Court's continuing endeavors to revise the application of *Roe v. Wade* to ongoing state efforts to regulate abortion rationally.

Nowhere does this appear more starkly than with the "live-birth" abortion.[85] Some have argued that the "freedom" protected by *Roe v. Wade* is not the freedom to be rid of an unwanted pregnancy, but the freedom to kill an unwanted child.[86] With the conviction of physicians for killing an aborted child after its birth alive,[87] we have come full circle to the days when the desire to be rid of unwanted pregnancies was expressed as infanticide rather than abortion. To translate unnecessarily, in effect if not in form, an asserted right to be rid of a pregnancy into the right to kill a child is indefensible. It makes a mockery of all efforts to deal with child abuse and mocks the values usually considered as embodied in our government.

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[85] Kleiman, *When Abortion Becomes Birth*, N.Y. Times, Feb. 15, 1984, at B1, col. 1. This had actually become a problem before *Roe v. Wade* was decided, although the leaders of NARAL kept the fact from the Court. L. Lader, *Abortion II* 164-166 (1973).

[86] *E.g.*, "For legal purposes, abortion means feticide: the *intentional* destruction of the fetus in the womb, or any untimely delivery brought about with intent to cause the death of the fetus.". G. Williams, *Textbook of Criminal Law* 290 (2d ed. 1983) (emphasis in the original).

[87] *E.g.*, Philadelhia Inquirer, Sept. 29, 1983, at 14A, col. 2.

CONCLUSION

We live in a world in which law and values are increasingly reshaped by science and technology. Nowhere has this process been more dramatic than regarding human reproduction. This case presents an opportunity to return the central questions posed by this developing technology to the political branches of government—branches that can acquire and assess the rapidly changing data to weigh its impact on societal needs and values. For the reasons advanced in this brief, *Roe v. Wade* should be overruled. Failing that, the application of *Roe v. Wade* should be reconsidered, and the state statutes upheld as consistent with the values and policies expressed in that decision.

Respectfully submitted,

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Appendix

TABLE OF CONTENTS

Page:

Appendix A: What Really Happened in *Rex v. de Bourton?* 1a

Appendix B: Other Representative Common Law Cases on Abortion 1b

APPENDIX A[1]

WHAT REALLY HAPPENED IN *REX v. de BOURTON?* *(a.k.a. the Twinslayer's Case)*

1327-1328

The Uncorrected, Incomplete Year Book Report of R. v. de Bourton
Y.B. Mich. 1 Edw. 3 f. 23 pl. 18 (1327)[2]

A writ issued to the sheriff of Gloucester to apprehend one D. who, according to the testimony of Sir G. Scrop, is supposed to have beaten a woman in an advanced state of pregnancy who was carrying twins, whereupon directly afterwards one twin died, and she was delivered of the other, who was baptized John by name, and two days afterwards, through the injury he had sustained, the child died: and the indictment was returned before Sir G. Scrop, and D. came, and pled Not guilty, and for the reason that the Justices were unwilling to adjudge this thing a felony, the accused was released to mainpernors, and then the argument was adjourned sine die. Thus the writ issued, as before stated, and Sir G. Scrop rehearsed the entire case, and how he [D.] came and pled.

Herle: to the sheriff: Produce the body, etc. And the sheriff returned the writ to the bailiff of the franchise of such place, who said, that the same fellow was taken by the mayor of Bristol, but of the cause of this arrest we are wholly ignorant.

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[1] The appendix is adapted from unpublished research of Dr. J.H. Baker of Cambridge University and of Mr. Philip Rafferty of the Los Angeles Bar. On Dr. Baker, *see* note 2 of the brief. All translations are Dr. Baker's. All footnotes are mine.

[2] This is the form of the case known to the later common law commentators such as Staunford, Coke, Hale, Blackstone, and Hawkins, as well as how it is known to all modern commentators. *See, e.g.*, Means II at 337.

The Corrected, Incomplete Year Book Report of R. v. de Bourton[3]

A writ issued to the sheriff of Gloucestershire to take one D., who (by the testimony of Sir Geoffrey Scoop) is supposed to have beaten a woman great with two children, so that immediately afterwards one of the children died, and she was delivered of the other, which was baptised by the name of Joan, but died two days later from the injury which the child had; and the indictment was returned before Sir Geoffrey Scrop; and D. came and pleaded Not guilty; and because the justices were not minded to treat[4] this thing as a felony, the indictee was released on mainprise [bail] and then this matter remained with a day set, and so the writ was issued as above, and it said that *by testimony of* Sir Geoffrey Scrop *etc.*, *and* recited the whole of the case *as above*, and how he came and pleaded etc., *and that the sheriff should have caused his body to come etc.*[5] And the sheriff returned the writ to the bailiffs of the franchise of such and such a place, who said that the person in question had been taken by the mayor of Bristol, but they were wholly unaware of the reason for the taking etc. *Therefore, a writ issued to the mayor of Bristol to cause the body to come, together with the cause etc.*

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[3] Dr. Baker uncovered this text by examining the four original manuscripts of the Year Book Report: Lincoln's Inn MS. Hale 72 at fo. 86v; Lincoln's Inn MS. Hale 116 at fo. 3; Lincoln's Inn MS. Hale 137(2) at fo. 11; Bodleian Library Oxford MS. Bodl. 363 at fo. 9v. The four agree with each other and differ from the printed version—some two centuries later than the manuscripts. Matters wholly omitted in the printed text are italicized. Dr. Baker's letter describing his search is on file with Mr. Rafferty.

[4] *d'agarder* ("to award") in all MSS.; *to adjudge* only in the printed version.

[5] The passage is garbled in the printed version, coming after the reference to C.J. Herle, who was Chief Justice of Common Pleas and not of the King's Bench [the court before which this case was heard].

The Original Court Records of Rex v. de Bourton
K.B. 27/270, Rex m.9 (Mich. term 1327)

Gloucestershire. The lord king has sent his writ to the sheriff of Gloucestershire in these words: Edward by grace of God king of England, lord of Ireland and duke of Acquitaine, to the sheriff of Gloucestershire, greeting! Because we have learned by the certificate of our beloved and faithful Geoffrey le Scrop, our chief justice, that Richard de Bourton has been indicted for that he entered the house of William Carles, tailor, at Bristol, and assaulted Alice, wife of the same William, being there greatly pregnant with two children, and with his hands beat and ill treated her, and violently knocked her to the ground, and with his feat so trampled upon the ground that he feloniously killed one of the aforesaid children in the belly of the same Alice its mother, and broke the head and arm of the other of the same children so that it was forthwith born and baptised by the name of Joan, and immediately after receiving her baptism died from the injury aforesaid; and that the foregoing matters still remain undetermined before ourself; and that this Richard had a day before us at a certain day now past for hearing the jury of the country on which, for good and ill, he put himself concerning the felony aforesaid, by mainprise of John le Traverner of Bristol and others named in the said certificate, who mainprised to have him before us at the said term; and on behalf of the selfsame Richard we are given to understand that by reason of the foregoing he has been taken, since the mainprise, and detained in our prison of Bristol, on account of which he could not come before us on the aforesaid day to stand to right upon the foregoing according to the law and custom of our realm: We, willing what is just to be done upon the foregoing, command you (as we commanded before) that if the same Richard is detained in the aforesaid prison by reason of the foregoing and not otherwise, and if he finds you sufficient mainpernors who mainprise him before us in a fortnight from Michaelmas day wheresoever we should then be in England, to do and receive what our court should decide in the foregoing, then cause the selfsame Richard to be meanwhile

delivered from prison by the mainprise aforesaid. And have you there the names of those mainpernors, and this writ. And if the same Richard is indicted for any other felonies or tresspasses in your county, then without delay send us distinctly and openly under your seal the tenor of the aforesaid indictment at the aforesaid day, that we may do further therein what by the law and custom aforesaid should be done, or else signify unto us the reason why you will not or cannot carry out our command heretofore directed unto you. Witness my self at Northallerton, the 14th day of July in the first year of our reign [1327].

By virtue of which writ, the sheriff (namely, Thomas de Rodbergh) returns that he commanded Everarrd Fraunceys and Robert Grene, bailiffs of the liberty of the vill of Bristol, who answered him that Richard de Bourten, lately indicted for the death of Joan, daughter of William Carles, tailor, at Bristol, as is contained in the writ, has not been taken by them the said bailiffs nor is for that reason detained in prison, but that he has been taken and detained by Roger Rurtels the mayor of the aforesaid vill for certain reasons which are unknown to them the said bailiffs etc.

And, after inspection of the aforesaid writ and return etc., the mayor and bailiffs of the vill of Bristol are commanded that if the same Richard finds sufficient mainpernors to be before the king in a fortnight from St. Hilary wheresoever etc. to hear the aforesaid jury and to do further and receive what the king's court should decide for him, then they cause the selfsame Richard to be meanwhile delivered from the aforesaid prison by the above-mentioned mainprise. And if he is indicted for any other felonies or tresspasses before them in the vill aforesaid, then they should distinctly and openly under their seals send that indictment (if any there be) or else the cause for which he was taken, to the king at the day aforesaid upon the incumbent peril, so that the lord king further etc. what is to be done etc.

At which day the mayor and bailiffs of the vill of Bristol return that the aforesaid Richard de Bourton did not or would not find sufficient mainpernors for being before the lord king at this day, namely in the quindene of St. Hilary etc., and to do

and receive what is commanded in the writ, as a result of which they did nothing further in executing the writ etc. And because the same mayor and bailiffs have not returned here before the king the names of themselves according to the form of the statute etc., and also have not answered etc. for what reason the aforesaid Richard de Bourton has been taken, as in the lord king's writ directed them therein was commanded, nor whether or not the aforesaid Richard is indicted for any other felonies or tresspasses before them in the vill aforesaid, the same mayor and bailiffs (namely, John le Romeseie, mayor, and Hugh de Langebrigge and Stephan Lespcier, bailiffs etc.) are in mercy. And they are assessed by the justices at 40s. And the sheriff is commanded that he should not omit by reason of the liberty of the aforesaid vill to enter the same etc., and if the same Richard should find him sufficient mainpernors to main prise to have him before the king in a fortnight from Easter day wheresoever etc. to hear the jury aforesaid etc. and further to do etc., then he should cause the selfsame Richard to be meanwhile delivered from the aforesaid prison by mainprise aforesaid etc. The sheriff is also commanded that he should not omit on account of the liberty to cause the aforesaid mayor and bailiffs to come before the king at the said term to answer the king for the return etc. Also the mayor and bailiffs are commanded that if the aforesaid Richard is indicted for any felonies and tresspasses before them in the aforesaid vill, then they should distinctly and openly under their seals send that indictment (if any there be) or else the cause for which he was taken, to the king at the day aforesaid etc. so that further etc.

The Original Court Records of Further Proceedings in R. v. de Bourton

K.B. 27/242, Rex m. 9 (Easter term 1328)

Gloucestershire. The jury at the suit of the lord king to make recognition etc. whether Richard de Bourton of Bristol is guilty of the death of Joan, daughter of William Carles, tailor of Bristol, slain in the suburbs of Bristol, whereof he has been indicted (as appears to the king by a certain indictment lately made thereof before the coroners of the vill of Bristol, and

which the king caused to come before him), is put in respite until the octaves of St. John the Baptist wheresoever etc., for want of jurors, because none [came] etc. Therefore, let the sheriff have the bodies of all the jurors before the king at the said term, etc. And let the aforesaid Richard meanwhile be released by the mainprise which heretofore found, from day to day until etc. And the sheriff is commanded that except for them etc. he should put in as many and such etc. and have them before the king at the said term etc.

The Original Court Records of the Conclusion of R. v. de Burton, K.B. 27/273, Rex m.12d (Octave of St. John, 2 Edw. III, 1328)

Gloucestershire. The jury at the suit of the lord king to make recognition of whether or not Richard de Bourton of Bristol is guilty of the death of Joan, daughter of William Carles, tailor of Bristol, feloniously slain in the suburbs of Bristol, whereof he is indicted—as appears to the king by a certain indictment lately made thereof before the coroners of the vill of Bristol, and which the king has caused to come before [himself] etc.—is put in respite until one month from Michaelmas day, wheresoever etc., for want of jurors, because none [came] etc. Therefore let the sheriff have the bodies of all the jurors before the king at the said date etc. Afterwards, the same term, the aforesaid Richard came and proffered a charter of the present lord king for pardon of the aforesaid felony, which is enrolled in Hilary term in the first year of the reign of our present king. Therefore he [is to go] thereof sine die etc.

Dr. Baker's Comments on the Problem of Deciding the True Course of Events in Rex v. de Bourton

These comments are from two letters from Dr. Baker to Mr. Rafferty, dated Nov. 6 and Dec. 12, 1985.

From the letter of Nov. 6:

"Richard de Bourton was indicted before the coroners of Bristol (1) for feloniously killing a child which died in the womb,

(2) for causing the death of the other (Christened Joan). We do not . . . have the indictment, though as summarized . . . [in the year book report] it does seem that the words of the felony applied to both children. In later entries, the offense is described only as the killing of Joan, but that may have been clerical shorthand.

"The indictment was removed into the King's Bench some time in the reign of Edward II. The indictment files do not survive. I discovered that the King's Bench held two goal deliveries in Gloucestershire in the 1320's, but the indictment is not recorded there (K.B. 27/247, Rex m.1d; K.B. 27/255, Rex m.24).

"Bourton pleaded Not guilty, and was released on mainprise to appear at some time before Michaelmas term 1327, but before his appearance he was arrested by the mayor and bailiffs of Bristol for some undisclosed cause . . . . [that] the judges were not minded to treat it as a felony . . . seems to me . . . was not a final determination of that question—indeed the record says that the issue of felony was still pending in 1328—but related only the bail application."

From the letter of Dec. 12:

"As I now see the case, the record shows that Bourton was indicted for feloniously killing a child which died in the womb of the mother and another (Joan) which died after birth and baptism; that he plead Not guilty, but was never tried; and that in Trinity term 1328 he was discharged on the strength of a pardon granted a year earlier. There is therefore nothing of record to show whether the court considered the facts alleged to amount to a felony or not, except insofar as the case was continued through several terms on the basis that it *was* a felony. (It could be, however, that only the killing of Joan was so regarded.) It is therefore the yearbook report that remains crucial, and this appears to say (in the middle) that Bourton was granted bail because the judges were not minded to treat it as a felony. The status and meaning of this pronouncement still

seem[s] to me less than clear. For one thing, it seems contrary to the record, which shows that the case was continued on the basis that a jury had been summoned to try whether Bourton was guilty of feloniously killing (what we should call manslaughter). That issue arose from Bourton's plea of not guilty, which the court had recorded. [T]here is therefore no question of the indictment having been quashed on the ground that it did not disclose a felony. Secondly, although it is probable that bail was not thought to be grantable for murder in medieval times (Y.B. 25 Edw. III, fo. 85; Coke, *Treatise on Bail & Mainprise;* Staunford P.C. 72a), it seems to have been allowable for felony.[6] It could hardly be argued that the release of Bourton on bail shows that if the facts were true he would not have been guilty of felony, because that again would be contrary to the record. I therefore do not really understand the year book in this respect, and suspect it may be a defective report.

"A pardon does not necessarily imply a legal doubt, at this date. Pardons were sometimes granted for favour. This case does look unusual however, because it appears from the patent roll (*Calendar Patent Rolls 1327-1330*, p. 113: Pat. 1 Edw. III, pt. 2, m.17) that Bourton was included in the general pardon of 29 May 1327 but with the special proviso that, unlike the other persons pardoned with him, he was to be excused from serving against the Scots. (The others were apparently ordinary felons conscripted into the army.)

"The pardon is not to be found in the roll for Hil. 1 Edw. III, which is defective."

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[6] The Statute of Westminster I (3 Edw. I, c. 15, 1275) provides that one indicted for homicide is not mainpernable or replevisable except when he is indicted on "light suspicion". Although Dr. Baker does not advert to "light suspicion", this might explain the apparent confusion in the Year Book reports of the case.

APPENDIX B[1]

OTHER REPRESENTATIVE COMMON LAW CASES ON ABORTION

Agnes' Appeal (1200)
1 Selden Soc'y 39 (no. 82 (1887)

Lincolnshire. Agnes, the daughter of Saxi, appeals John of Paris that whereas she was in labor, he came to her house and dragged her out by the feet and struck her with a certain pole in such a way that she lost her child. And the citizens of Lincoln came and showed a charter of the lord king which witnesses that they should not be impleaded outside the walls of Lincoln (except for their moneyers and officials), and that they ought not to make battle concerning any appeal but to deraign themselves[2] according to the liberties and laws of the city of London;[3] and they prayed this liberty. A day is given to them before the lord king wheresoever he should then be in England on the morrow of St. Edmund to hear their judgment.[4]

Gundwine's Appeal, Just. 1/274, m.14d (1247)

Amice, who was the wife of Ralph Gundwine, appeals Adam Warner, William Warner and Henry Warner that they came to the house of her the said Amice and broke her house, and took her the said Amice and beat her severely so that, by reason of that beating, she the said Amice lost her child which was in her belly. And that they did this to her wickedly and feloniously against the peace etc., she offers etc.

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[1] When translations were necessary (*see* the table of contents), in order to achieve consistency, I have used original translations provided by Dr. J.H. Baker (*see* Appendix A n.1) to Mr. Philip Rafferty. All footnotes are mine.

[2] *I.e.*, To vindicate themselves or to prove their innocence.

[3] *I.e.*, trial by wager or law — through oath-helpers.

[4] The outcome has not been found.

And the aforesaid Adam and others come and deny the [breach of the peace], the beating, and the whole etc. and put themselves upon a jury of the township. And they offer the lord king 50 pounds for having the jury therein, by pledge of [12 names].

And the jurors say upon their oath that in truth the aforesaid Adam and others beat the aforesaid Amice; but they say that she immediately went off, and walked about hither and thither, and afterwards when eight days had elapsed she aborted a certain child having the form of a male five inches long; but they believe that this was rather due to the labor and foolish behavior[5] of the selfsame Amice than to the aforesaid beating.

Juliana's Appeal (1256?), Somerset Pleas (Civ. & Crim.) from the Rolls of the Itinerant Justices 321 (no. 1243) (C. Chadwyck-Healy ed. 1897)

John de Rechich beat one Juliana, daughter of Maynard, so that he killed her boy in her womb, and fled. Therefore let him be exacted and outlawed. He was received at Stoke Curcy. Therefore [that township] is in mercy.[6] The jurors concealed that matter; therefore they are in mercy. He had no chattels.

Rex v. Anonymous (aka. The Abortionist's Case) (K.B. 1348) Fitzherbert, Graunde Abridgement, tit. Corone, f. 268, pl. 263 (1st ed. 1516)[7]

One was indicted for that he killed a child in its mother's belly, and the opinion [was] that he shall not be arraigned on

[5] *stultum gestum*.

[6] *I.e.*, to be amerced: to pay a fine in lieu of more serious punishment.

[7] Dr. Baker, in a letter to Philip Rafferty (Dec. 12, 1985), indicated that the case does not appear in the various Year Books for 1348, and cannot be traced back before Statham's *Abridgment* (c. 1490, f. 58, pl. 91), which is reproduced in Fitzherbert's *Abridgement*.

this since no name of baptism was in the indictment, and also it is hard to know whether he killed it or not etc.

Rex v. Lichefeld

K.B. 27/974, Rex. m.4 (1505)

Nottinghamshire. Heretofore, namely on the vigil of the Epiphany of [our] Lord in the nineteenth year of the reign of the present lord king [Jan. 5, 1504], at Basford in the aforesaid county, before Richard Parker one of the said lord king's coroners in the aforesaid county upon the view of the body of Jane Wynspere of Basford aforesaid, it was presented by the oath of twelve jurors that the said Jane Wynspere of Basford in the county of Nottingham, single woman, being pregnant,[8] on the twelfth day of December in the year above mentioned [1503] at Basford aforesaid, being inspired by the devil drank various bad and [pure][9] potions in order to kill and destroy the child in her body, and took them into her body, as result of which the said Jane then and there died, and thus the same Jane in manner and form aforesaid feloniously and as a *felo de se* slew and poisoned herself and the child in her body; and that Thomas Lichefeld of Basford in the county aforesaid, cleric, knowing that the said Jane had committed said felony in form aforesaid, then and there feloniously harbored *the* said Jane . . . .

On the Thursday after the quindent of Hilary [Jan. 30, 1505], Lichefeld comes in custody and demurs to the indictment on the ground that the principal is dead and that he cannot answer without her. The court adjudges that he is discharged *sine die*.[10]

[8] *puerpera:* perhaps "in labor".

[9] *immaculata*, which Dr. Baker suggests here should be translated as "polluted" although it means the opposite; perhaps, the *im-* here refers to putting something in the potion rather than to negative *-maculata*.

[10] Note that the lack of the allegation "*contra pacem*" in the indictment would also have been sufficient grounds for a demurer.

The Endorsement of the Indictments After Mandamus for Removal to the King's Bench, K.B. 9/513/23d (1530)

TRUE BILL taken at St. John's Street in the county of Middlesex before Sir John More, knight, Robert Wroth, Robert Chesemen, John Brown, Richard Hawkes, and John Palmer, keepers of the peace of the lord king and the same king's justices assigned to hear and determine various felonies, tresspasses, and misdeeds in the county of Middlesex, on the Thursday next after the feast of the Conception of the Blessed Virgin Mary in the twenty-first year of the reign of King Henry VIII [Dec. 9, 1529], by the oath etc. of . . . jurors[11] delivered before the lord king on the Saturday next after the quindene of St. John this same term [July 9, 1530], by the hand of the aforesaid John More, one of the aforesaid justices, in order to be determined.

[Sewn to the bill, in the King's Bench file, is a writ dated April 29, 1530, ordering the justices of the peace for Middlesex to send all indictments concerning William Wodlake for appearance "before the king", i.e., before the King's Bench. The writ, tested by Chief FitzJames, is endorsed by Sir John More that all indictments concerning Wodlake have been sent according to the tenor of the writ.]

In the Controlment Roll of the Clerk of the Court, K.B. 29/162/m.11d (1531)

Middlesex. William Wodlake (dead) of the parish of St. Clement Danes in the county aforesame, net-maker, is to be taken [and brought here] in the octave of Michaelmas [to answer] for various felonies, murders, and misdemeanors of which he is indicted . . . . Afterwrds, in Hilary term 22 Henry VIII [1531] he is to be taken [and brought here] in the quindene of Easter: at which day he is dead. Therefore let the process against him here totally cease.

[11] Of the grand jury.

***Cockaine v. Witnam*, Hil., 19 Eliz. 1 (1577)**
(Action for Slander)

Version 1, Brit. Lib., Ms. Landsdowne 1067, fo. 97

"The Lady Cockeyn [*sic*] offered A.B. her maid a drink in order to murder her child, because her butler had gotten it." And although this was not murder, for the infant was *en ventre sa mere*, the action nevertheless lay.

Version 2: Cro. Eliz. 49, pl. 4 (1586)

Action for words. At the Nisi Prius the defendant pleaded *concord puis le darraine* continuance, judgment *si al enquest*, etc. And by all the justices it was no plea, but he ought to conclude, judgment *si actio*, etc., and so in all pleas pleaded since the last continuance.

Then it was moved, if judgment shall be given upon this, or a new Nisi Prius be granted; and upon good advice judgment was given for the plaintiff, for it was a confession of the matter in issue.

The words were "My Lady Cockaine did offer two shillings to a woman with child, to get her a drink to kill her child, because it was gotten by J.S. Sir Thoma Cockaine's butler." And it was moved the action did not lie for these words; but it was adjudged for the plaintiff, for by them the lady's credit is impaired; and, if true, there was cause to bind her to good behavior, although it was not said she did give money, or any hurt was done, but that she offered etc. This case was adjudged Hill. 19 Eliz. Intratur, Mich. 17 & 17 Eliz. Rot. 183. *Ex relatione* Chamberlaine. *Vide* 4 Co. 16.b.

Version 3: Harv. L.S. Lib. Ms. 1180(1), fo. 387

For this he vouched a case in Michaelmas 17 & 18 Eliz., roll 483, between Sir John Cockin [*sic*] and his wife and one Wyman [*sic*], because Wyman spoke these words, "My lady Cockin did offer one Bash 10 pounds to get her a drink to destroy the child she went withall, because Mr. Cockin's butler had begotten it";

and it was ruled that an action lay, and yet he did not say that a drink was got, but only an offer to get . . . .

Regina v. Turnour, Assize 35/23/29 (Essex 1581)

Essex: The jurors for [our] lady the queen present that Jane Turnour of Stisted in the aforesaid county, spinster, being a common witch and enchantress, not having God before her eyes, but being seduced by the instigation of the devil, on the eight day of January in the twenty-second year of the reign of the Lady Elizabeth [1580], Queen of England, France, and Ireland, defender of the faith, devilishly and maliciously at Stisted aforesaid, on various days and occasions both before and since, maliciously and devilishly bewitched and enchanted a certain Helen Sparrowe, wife of John Sparrowe, in the body of the same Helen, being then great with a certain living child, by reason whereof not only was the same Helen then and there on various occasions gravely vexed in her body horribly troubled, to the greatest danger of her life, but also the aforesaid child (of which the same Helen was then and there great) then and there came to death. And thus the aforesaid jurors say upon their oath that the aforesaid Jane Turnour, in manner and form aforesaid, on the day in the year aforesaid, at Stisted aforesaid, maliciously and devilishly bewitched and enchanged the aforesaid Helen Sparrowe, and deprived the living child (of which the aforesaid Helen was then pregnant) of his life by reason of these enchangments and bewitchings, contrary to the form of the statute made and provided for such cases, and to the bad and pernicious example of all other offending in such cases, and against the peace of the said present lady the queen. [Note by the clerk:] Puts herself on the country;[12] guilty judgment.

Regina v. Sims, 75 Eng. Rep. 1075 (Q.B. 1601)

Tresspasse and assault was brought against one Sims by the Husband and the Wife for beating of the woman.

[12] *I.e.*, accepts trial by jury.

Coke [Attorney-General]: the case is such, as appers by examination. A man beats a woman which is great with child, and after the child is born living, but hath signes, bruises in his body, received by the said batterie, and after dyed thereof, I say that this is murder.

Fenner & Popham [JJ.], *absentibus caeteris*, clearly of the same opinion, and the difference is where the child is born living, for it be dead born it is no murder, for *non constat*[13] whether the child were living at the time of the batterie or not, or if the batterie was the cause of the death, but when it is born living, and the wounds appear in his body, and then he dye, the Batteror shall be arraigned of murder, for now it may be proved whether these wounds were the cause of the death of not, and for that if it be found, he shall be condemned.

Regina v. Webb (Q.B. 1602), Calendar of Assize Rec., Surrey Indictments, Eliz. 1 at 512 (no. 3146) (J. Cockburn ed. 1980)

Surrey. The jurors for our Lady the Queen present, that Margaret Webb, lately of Godalmyn, spinster, on the tenth day of August, in the forty-first year of the reign of our Lady Elizabeth [1599] by the grace of God Queen of England, France and Ireland, and defender of the faith, with force and arms, and at the aforesaid Godalmyn in the aforesaid county, not having the fear of God before her eyes, but moved and seduced by the instigation of the devil, once ate the poison called "ratesbane" with the intention of spoiling and destroying the infant in the womb of Margaret herself and thus the aforesaid Margaret, by reason of eating the aforesaid poison, spoiled and destroyed then and there the infant in her womb, as a pernicious example to all malefactors offending in like manner, against the peace of our Lady Queen, her crown and dignity.

[13] It cannot be proved.

***Proprietary v. Mitchell*, 10 Md. Arch. 171-186 (1652)**

[The following record of the trial is found at 10 Md. Arch. 182-185; the remainder of the citation consists of extensive depositions providing the evidence brought against Captain Mitchell to prepare the charges.]

The Court this day took into Consideration a Peticon exhibited by Capt. William Mitchell who intended (as it Seems) to have preferred the Same to the Assembly had it gone on the Peticon being as followeth vizt.:

To the Honble the Assembly for regulateing the affairs of the Province of Maryland:

The humble Peticon of Capt. Wm. Mitchell Humbling Shewing That your Peticoner was on Saturday last comitted prisoner to the Common Goal upon a Warrant Signed by Robert Brooke Esq., In which your Peticoner Stands charged in general words with Murther, Atheisme, and Blasphemy, Crimes never in the least acted or within the Intention of your Peticoner. Your Peticoner therefore humbly prays he may be Speedily called to his Answer, and have his liberty restored in Case noe crime in Law be proved against him that warrants his Imprisonment upon the warrant before menconed, And that his Natural filing for which God hath pleased to afflict and humble your Peticoner, may not be pressed against your Peticoner in Cases wherein the Laws of England are Silent, And your Peticoner Shall ever pray.

[Signed] Wm. Mitchell

Upon reading of which Peticon the Court gave direction for a Speedy tryall whereupon his Lordships Attorney, Mr. Hatton, brought in his charge as followeth, vizt.:

May it please this Honble Court: It is fallen to my Lott upon the alteracon in the Government[14] as Attorney to the Lord-

[14] This probably refers to the displacement of the Catholic government of the colony by its first Protestant government in 1652, *Worldmark Encyclopedia of the States* 242 (1981).

Proprietary to be prosecutor against Capt. William Mitchell now prisoner here upon Mr. Brookes Warrant, I could have wished there been no Such occasion, The Crimes for which I am to charge him being Soe many and Soe heynous, that I have not known or heard of the like, It troubles me the rather in regard the Lord Baltemore hath been formerly Soe deceived in him as to place him here in the Seat of Judicature, which by his Scandolous course of life and gross haynous offences, he hath extreamly abused, Whereas he ought (especially Soe placed) to have given good example to others and to imploy that Talent and those abilities of witt and understanding (which almighty God hath indeed in a large measure bestowed on him) to his glory and the publick good, But by Common experience it is apparent, that the chiefest use he hath made thereof hath been to colour over his Villanous Courses, and to mock and deride all Religion and Civil Government, As the Court (in part) take notice by the particulars of his Charge being as followeth Vizt.:

The charge of the Lord Proprietary's Attorney by way of Indictment against Capt. William Mitchell in the name of the Keepers of the Liberties of England by Authority of Parliamt. First: That by his expressions as well as practice (as will as I conceive appear by proofe) he hath not only professed himself to be an Atheist, but hath also endeavoured to draw others to believe there is noe God, Makeing a Common practice by blasphemous expressions and otherwise to mock and deride God's Ordinances, and all Religion, thereby to open a way to all wicked listfull licentious and prophane Courses. Secondly: That he hath Committed Adultery with one Susan Warren. Thirdly: That he hath Murtherously endeavoured to destroy or Murther the Child by him begotten in the Womb of the Said Susan Warren. And is much Suspected (if not known) to have brought his late wife to an untimely end in her late Voyage hiterward by Sea. Fourthly: That (as I conceive will appear by proofe) he hath Since his late wife's death lived in fornication with his now pretended wife Joane.

And for these and other grosse Crimes and Misdemeanors

(sufficiently I conceive) appearing by proofe, My humble request is that the prisoner may be brought to his Answer, and upon a Speedy tryall may receive punishment according to Justice to God's glory and discharge of the Government in that particular.

To which charge the Said Capt. Mitchell the prisoner by his Answer pleading not Guilty, made Choice to be tryed by a Jury Whereupon these persons following were warned to be of the Grand Jury for the tryall vict: . . . , who being all particularly called by name and attending the Court, The prisoner being demanded whether he could take any personal excepcon against any of them, expressed that he could not but was well Satisfied therein. Whereupon the Jurors were Sworn and their charge given them to bring in a Just and true verdict upon every branch of the Attorneys Charge aforesaid according to evidence to the best of their Skill who after much time Spend therein brought in their Joynt verdict in the words following vixt.:

Vera[15] to the first Soe far as one Deposition with Sundry Circumstances thereunto agreeing Shall be thought valid in Law.

To the Second, third, and fourth: *Billa Vera*.

After the bringing of which verdict the Court discharged the Jurors and the day being far Spent and by reason of other Occasions, the Governor adjourned the Court till the day following.

. . .

Capt. William Mitchell this day referred himself wholly to the determination and Judgement of the Court for all matters charged against him upon which the Grand Jury had given in their verdict the day before not desiring that the Court Should

[15] "True bill" — a good indictment.

be troubled with impannelling another Jury for the further tryall thereof.

This Court therefore takeing the matter into Serious Consideracon upon the perusal of the proofs and in pursuance of the verdict of the Grand Jury for his Several Offenses of Adultery, fornication and Murtherous intention, and in respect of his lewd and Scandalous Course of life Sufficiently appearing upon the proofs doth Order that the Said Capt. Mitchell Shall forthwith pay Five thousand pounds of Tobacco and Cask or the value thereof as a Fine to the Lord Proprietary, And to enter into bond for his good behavior. And that he and his now pretended wife Joane be Seperated till they be Joyned together in Matrimony in the usual allowed Manner, And that paying the Court Charges of imprisonment he is to be discharged of his Imprisonment in the particular.

Rex v. Beare (Derby, England, Aug. 15, 1732)
2 The Gentleman's Magazine 931 (Aug. 1732)

ELEANOR MERRIMAN, now the wife of *Ebenezer Beare*, indicted for a Misdemeanor, in endeavouring to persuade Nich. Wilson to poison his Wife, and for giving him Poison to that End.

Indicted a second time by the Name of *Eleanor Beare*, for a Misdemeanor, in destroying the Foetus in the Womb of *Grace Belfort*, by putting an iron Instrument up into her Body, and thereby causing her to miscarry.

Indicted a third time, for destroying the Foetus in the Womb of a certain Woman, to the jury unknown, by putting an Iron Instrument up her Body, or by giving her something to make her miscarry. Pleaded Not Guilty.

. . .

To the Second Indictment

COUNSEL: Gentlemen, you have heard the Indictment read, and may observe, that the Misdemeanor for which the

Prisoner stands indicted, is of a most shocking Nature; to destroy the Fruit in the Womb carries something in it so contrary to the natural Tenderness of the Female Sex, that I am amazed how ever any Woman should arrive at such a degree of Impiety and Cruelty, as to attempt it in such a manner as the Prisoner has done, it has really something so shocking in it, that I cannot well display the Nature of the Crime to you, but must leave it to the Evidence: It is cruel and barbarous to the last degree.

Call *Grace Belfort*.

GRACE BELFORD [sic]: I lived with the Prisoner as a Servant about ten Days, but was not hired, and I was off and on with her about fourteen Weeks: When I had been with her a few Days there came Company into the House, and made me drink Ale and Brandy (which I was not used to drink) and it overcame me; my Mistress sent me unto the Stable to give Hay to some Horses, but I was not capable of doing it, so [I] laid me down in the Stable; and there came to me one Ch____r, a young Man that was drinking in the House, and after some Time I feared I was with Child by Ch____r; upon that, my Mistress asked me if I was with Child, I told her I thought I was; Then she said if I could get 30 shilling from Ch____r, she would clear me from the Child, without giving me Physick. A little Time after, some Company gave me Cyder and Brandy, my Mistress and I were both full of Liquor, and when the Company was gone, we could scarce get up Stairs, but we did get up; then I laid me on the Bed, and my Mistress brought a kind of an Instrument, I took it to be like an Iron Skewer, and she put it up into my Body a great Way, and hurt me.

COURT: What followed upon that?

EVIDENCE: Some Blood came from me.

COURT: Did you miscarry after that?

EVIDENCE: The next Day after I went to *Allesiree*, where I had a Miscarriage.

COURT: What did the Prisoner do after that?

EVIDENCE: She told me the Job was done. I then lodged two or three Nights with one *Ann Moseley* (now *Ann Oldknowles*) and coming one Morning to see the Prisoner, I called for a Mug of Ale and drank it, and told her I was going home; then came in *John Clark*, and on the Prisoner's saying I was going home, he said he would give me a Glass of Wine to help me forward, which accordingly he did, out of a Bottle he had in his Pocket, then I took my leave of him; and when I was a little Way out of Town, I fell down at a Style, and was not well, I lay a little while, then got up, and went to *Nottingham* that night.

Call *Ann Oldknowles*.

COURT: Do you know any Thing of *Grace Belford* having a Miscarriage?

EVIDENCE: I know nothing, but that when she lay with me, I saw all the Symptoms of Miscarriage on the Bed where she lay.

Call *John Clark*.

COURT: Do you know the Prisoner?

EVIDENCE: Yes, I have frequented her House.

COURT: Did you ever hear her say anything that she had used Means to make a Woman with Child miscarry, by putting any kind of Instrument up their Bodies, or by giving them any Thing to take inwardly?

EVIDENCE: Yes, I have. ——

COURT: Have you seen her Instrument for that Purpose, or have you seen her use any Means to make any Woman with Child miscarry?

CLARK: No, but I have heard her say she had done it, and that she then had under her one *Hannah* _____, whose other Name I know not.

COURT: Have you heard her say she had been sent for for these wicked Practices, or had any Reward for causing any one to miscarry?

CLARK: I heard her say she had been once sent for to *Nottingham*, and, as I remember, she said she had five Pounds for the Journey.

PRISONER: Did you not say you never heard me say any thing of using any Means to cause Miscarriage in any Person, or saw me use any Means for that End?

CLARK: No, I said I never saw you do any thing that Way, but had heard you say you had done it. Would you have me forswear myself?

PRISONER: No, but I would have you speak the Truth.

CLARK: I do.

Then the Prisoner called several Persons to speak in her Behalf, but only two appeared, and they only gave her Friends a reputable Character, and said the prisoner had a good Education, but they knew nothing of the latter Part of her Life.

MR. MAYOR: The Prisoner at the Bar has a very bad Character, and I have had frequent Complaints against her for keeping a disorderly House.

Many evidences were ready in Court to have proved the Facts she stood charged with in the third Indictment; but his Lordship observing that the second Indictment was proved so plainly, he thought there was no Necessity for going upon the third.

His Lordship summed up the Evidence in a very moving Speech to the jury, wherein he said, he never met with a Case so barbarous and unnatural. The Jury, after a short Consultation, brought the Prisoner in Guilty of both Indictments, and she received sentence to stand in the Pillory, the two next Market-Days, and to suffer close Imprisonment for Three Years.

Derby, August 18, 1732. This day *Eleanor Beare*, pursuant to her Sentence, stood for the first Time in the Pillory in the Market place; to which Place she was attended by several of the Sheriff's Officers; notwithstanding which, the Populace, to show their Resentment of the horrible Crimes wherewith she had been charged, and the little Remorse she has shown since her Commitments, gave her no Quarter, but threw such quantities of Eggs, Turnips, etc. that it was thought she would hardly have escaped with her Life: she disengaged herself from the Pillory before the Time of her standing was expired, jumped among the Crowd, whence she was with Difficulty carried back to Prison.

Rex v. Tinckler (August, 1781)

The Report in the Newcastle Chronicle, Nov. 24, 1781, at 2

Tuesday last Margaret Tinckler, midwife, was executed near Durham, for a crime in acting or recommending certain means to destroy an infant, which was effected; and finally with the death of the mother. Before she left the jail for execution, she confessed to a worthy Clergyman, and Mr. Smith, surgeon in Newcastle, then present, that she only recommended the means, but that the act itself was done by the deceased woman . . . [Her plea of pregnancy failed.]

The Published Report, 2 E. East, A Treatise of the Pleas of the Crown 354-356 (1803)[16]

Magaret Tinckler was indicted for the murder of Jane Parkinson, by inserting pieces of wood into her womb. A second count charged her as accessary before the fact. It was proved by several witnesses, that from the first time of the deceased taking to her bed, which was on the 12th of July, she thought that she must die, making use of different expresses, as, *that she was going; that she was working out her last;* and exclaim-

[16] This report, which is the one by which the case is generally known, has been verified by Dr. Baker against the original records of the case.

ing, *Oh! that Peggy Tinckler has killed me*. She lingered till the 23d, when she died. She never was up but once during that time, when on telling a friend who attended her that she thought herself better, she advised her to get up, which the deceased did, and walked as far as the passage going out of the room, but was forced to return and go to bed again. It appeared by the testimony of several witnesses, that from the moment of her taking to her bed till the time of her death she had declared, *that Tinckler had killed her and dear child*, (stating the particular means used, which agreed with the charge in the indictment.) And during the same period she had declared more particularly, "that she was with child by one P. a married man, who, being fearful lest his wife should hear of it if she were brought to bed, advised her to go to the prisoner, a midwife, to take her advice how she should get rid of the child, being then five or six months gone." "That the prisoner gave he the advice" in question, which she followed accordingly. It was proved by the testimony of a witness, that three days before the delivery, which was on the 10th of July, she saw the deceased in the prisoner's bed-chamber, when the prisoner took her round the waist and shook her in a very violent manner six different times, and tossed her up and down: and that she afterwards delivered at the prisoner's house. The deceased also declared during her illness, that after her delivery the prisoner gave her the child to take home; and bid her to go to bed that night and sleep, and get up in the morning and go about her business, and nobody would know anything of the matter; but that appearing very ill the next day at a relation's house, they had ordered her to go home and go to bed, which she did. The child was born alive, but died instantly; and the surgeons, who were examined, proved that it was perfect. There was no doubt but that the deceased had died by the acceleration of the birth of the child: and upon opening her womb it appeared that there were two holes caused by the skewers, one of which was mortified, and the other only enflamed; and other symptoms of injury appeared. A short time before her death she was asked whether the account she

had from time to time given of the occasion of her death, and the prisoner's treatment of her were true; and she declared it was. It was objected that the above evidence of the deceased's declarations ought not to be admitted, as she herself was *particeps criminis*, and likewise as it appeared at the time of her declarations she was better, or thought herself so. But Nares J. was of opinion, that however this objection might hold with respect to the second count, in which the prisoner was charged as an accessory to the deceased, yet the deceased was not willingly or knowingly an accessary to her own death; and therefore it was like the common case of any other murder. And as to the objection that she once thought herself better, and tried to get up, yet the same declarations she then made had been made repeatedly before to persons whom in confidence she told that she never should survive, when she first took to her bed; and she had repeated the same declarations the day before she died, and within a few hours of her death. And as to the fact itself, he was clearly of opinion it was murder on the authority of Lord Hale. The jury found the prisoner guilty on the first count, charging her as a principal in the murder, and execution being respited to take the opinion of the judges on the whole case, they all met to consider of it: and were unanimously of opinion that these declarations of the deceased were legal evidence: for thought at one time the deceased thought herself better, yet the declarations before and after and home to her death were uniform and to the same effect. And as to her being *particeps criminis*, they answered, that if two persons be guilty of murder, and one be indicted and the other not, the party not indicted is a witness for the crown. And thought the practice be not to convict on such proof uncorroborated, yet the evidence is admissable; and here it was supported by the proof of the prisoner tossing the deceased in her arms in the manner stated. Most of the judges indeed held that the declarations of the deceased were alone sufficient evidence to convict the prisoner; for they were not to be considered in the light of evidence coming from a *particeps criminis;* as she considered herself to be dying at the times, and had no view or intent to

serve in excusing herself, or fixing the charge unjustly on others. But others of the judges thought that her declarations were to be so considered; and therefore required the aid of confirmatory evidence.

AMICUS CURIAE

BRIEF

(11) (9)

Supreme Court, U.S.
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Nos. 88-790, 88-1309

IN THE

Supreme Court of the United States

October Term 1989

No. 88-790

BERNARD J. TURNOCK et al., *Appellants*,

v.

RICHARD M. RAGSDALE et al., *Appellees*.

On Appeal from the United States Court of Appeals for the Seventh Circuit

No. 88-1309

STATE OF MINNESOTA et al., *Cross-Petitioners*,

v.

JANE HODGSON et al., *Cross-Respondents*.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

BRIEF AMICUS CURIAE OF THE NATIONAL RIGHT TO LIFE COMMITTEE, INC. IN SUPPORT OF APPELLANTS IN *TURNOCK* AND CROSS-PETITIONERS IN *HODGSON*

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QUESTION PRESENTED HEREIN

Is the decision of this Court in *Roe v. Wade* sufficiently implicated in the cases at bar, *Turnock v. Ragsdale* and *Minnesota v. Hodgson*, for *Roe v. Wade* to be reconsidered?

TABLE OF CONTENTS

Page:

Question Presented Herein i

Table Of Contents ii

Table of Authorities v

Interest Of Amicus 2

Summary Of Argument 3

Argument 4

Introduction 4

I. A Logical, Coherent Analysis Governing The Constitutional Necessity For This Court To Decide A Constitutional Issue Is Discernible From Precedent 5

A. Four Elements Govern the Consitutional Necessity of Deciding A Constititutional Issue Under this Court's Precedents 5

1. This Court has a duty to interpret the Constitution 5

2. This Court's duty to interpret the Constitution is limited by Article III of the Constitution . 7

3. This Court's duty to interpret the Constitution is limited by its jurisdictional statutes 8

4. This Court's duty to interpret the Constitution is limited by prudential considerations 9

B. These Four Elements Form a Logical, Sequential Analysis to be Employed in Analyzing the Necessity of Deciding a Constitutional Issue 10

C. Consideration of Some Specific Questions Concerning Reconsideration Reveal that Reconsideration of *Roe v. Wade* Is Appropriate in this Case 11

II. The Failure Of This Court To Agree Upon And Follow Such An Analysis Concerning Reconsideration Has Introduced Chaos Into The Law And Into This Court 15

A. That this Court Has Not Agreed Upon an Analysis for Reconsideratilon Is Evident from this Past Term 15

B. *Roe v. Wade* Demonstrates the Overreaching Possible with an Inadequate Analysis and the Resultant Overruling Required 17

C. *Webster* Demonstrates the Underreaching Possible with an Inadequate Analysis and the Resultant Chaos Attending Such Action 19

1. Is the *Roe* trimester scheme overruled *sub silentio?* 21

2. Is the abortion right now a liberty interest? . 22

3. Is *Akron* overruled *sub silentio* by rehabilitation of the unduly burdensome test? 23

III. Employing The Proper Analysis To The Issue Of Reconsideration Herein Reveals That *Roe v. Wade* Should Be Reconsidered In These Cases 24

A. This Court Should Go Through the Full Analysis to Determine What Issues Should be Decided and on What Grounds 24

B. The Issue of Reconsideration Itself Is Not One Which This Court May Avoid if It Chooses to Decide These Cases and Issue a Written Opinion

Because *Roe* and its Right and Analysis are Clearly Implicated 25

1. Compelling state interests in maternal health and unborn life, which underlie these statutes, are asserted throughout pregnancy 26

2. The right to effecutate the abortion decision is implicated 27

3. The right to consult one's physician in making the abortion decision is forbidden 27

Conclusion 29

TABLE OF AUTHORITIES

Cases *Pages*

Akron v. Akron Center for Reproductive Health, 462 U.S. 416 (1983). 12, 16, 19, 21-24

Ashwander v. TVA, 297 U.S. 288 (1936) 6-10

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IN THE

Supreme Court of the United States

October Term 1989

No. 88-790

BERNARD J. TURNOCK et al., *Appellants*,

v.

RICHARD M. RAGSDALE et al., *Appellees*.

On Appeal from the United States Court of Appeals
for the Seventh Circuit

No. 88-1309

STATE OF MINNESOTA et al., *Cross-Petitioners*,

v.

JANE HODGSON et al., *Cross-Respondents*.

On Petition for a Writ of Certiorari to the United States
Court of Appeals for the Eighth Circuit

BRIEF AMICUS CURIAE OF THE NATIONAL RIGHT TO LIFE COMMITTEE, INC. IN SUPPORT OF APPELLANTS IN *TURNOCK* AND CROSS-PETITIONERS IN *HODGSON*

INTEREST OF AMICUS[1]

The National Right to Life Committee, Inc. is a nonprofit organization whose purpose is to promote respect for the worth and dignity of all human life, including the life of the unborn child from the moment of conception. The National Right to Life Committee, Inc. is comprised of a Board of Directors representing 51 state affiliate organizations and more than 2,000 local chapters made up of individuals from every race, denomination, ethnic background, and political belief. It engages in various political, legislative, legal, and educational activities to protect and promote the concept of the sanctity of innocent human life.

The members of the National Right to Life Committee, Inc. have been the prime supporters of laws restricting abortion on demand to only those instances in which the mother's life is in danger. Since *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973), the members of the National Right to Life Committee, Inc. have supported legislation to protect unborn human life within these guidelines. The Illinois and Minnesota legislation at issue herein is the result of lobbying, in great part, by the members of the National Right to Life Committee, Inc. and its Illinois and Minnesota affiliates, Illinois Federation for the Right to Life and Minnesota Citizens Concerned for Life. By means of this brief, the National Right to Life Committee, Inc. seeks to advance these interests by supporting the Minnesota regulations at issue herein.

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[1] This Brief Amicus Curiae is filed with the consent of all parties to this appeal. A letter from each attorney stating this consent has been filed with the Clerk of this Court.

SUMMARY OF ARGUMENT

In *Webster v. Reproductive Health Services*, members of the majority differed on whether and to what extent *Roe v. Wade* should be reconsidered. From the decisions of this Court, a logical, coherent, and sequential analysis may be constructed to govern when it is necessary to decide a constitutional issue, in fulfillment of this Court's constitutional duty to decide a case properly before it. Failure to follow this analysis has resulted in anomalous results, evident in the decisions of this Court in the last term, and confusion in the law, evident in the wake of *Webster*.

Applying this analysis, it is clear that reconsideration of precedent is required whenever a case is brought on the basis of the right and/or analysis created in that precedent. The right declared and the analysis to be employed in constitutional review are but means of applying the Constitution. The ultimate question in constitutional review is what the Constitution requires. This is always at issue in constitutional review, making the case declaring a right and/or analysis always at issue in such cases. Thus, the Court must always establish the standard of review, either implicitly or explicitly, in determining the constitutionality of a statute.

Furthermore, a court is required to give a reasoned, legal justification for its decision. This must resolve those constitutional issues embraced by an analysis of the case. This requires resolution of the issues associated with the standard of review. Thus, a precedent which establishes a constitutional right or sets forth the analysis to be employed in determining the constitutionality of a statute under that right must be reconsidered whenever the constitutionality of a statute is challenged on the basis of that right or employing that analysis. Therefore, reconsideration of *Roe v. Wade* may not be avoided in the cases at bar.

Moreover, although sufficient implication of *Roe* for reconsideration of that case is inherent in its seminal status, the

cases at bar implicate *Roe's* core analysis more fully than did *Webster.* Additionally, the confusion created by *Webster* itself implicates the heart of Roe's analysis, making reconsideration based upon the effect of that decision alone a constitutional necessity. Therefore, *Roe v. Wade* should be reconsidered in the cases at bar.

ARGUMENT

INTRODUCTION

The decision of this Court in *Webster v. Reproductive Health Services*, 109 S.Ct. 3040 (1989), settled the small portion of abortion jurisprudence encompassed by the Missouri statutes at issue in that case. But *Webster* settled these matters in a way which unsettled the remainder of abortion law.

Issues now unresolved go to the very core of this Court's opinion in *Roe v. Wade*, 410 U.S. 113 (1973). Were *Roe* and/or its later progeny overruled sub silentio in *Webster?* Is a woman's interest in obtaining an abortion a fundamental right, a limited fundamental right, or a liberty interest? Will abortion legislation now be reviewed under the traditional compelling interest standard or is an unduly burdensome analysis the de facto standard? What is an undue burden? Is the trimester scheme overruled or yet viable? Must abortion regulations be narrowly tailored to effectuate the underlying state interest or only reasonably related to the interest?

This confusion arose from the inability of the members of this Court to agree on the analysis to be employed in determining when constitutional necessity requires the reconsideration of precedent. The majority which decided Webster disagreed over whether and to what extent *Roe v. Wade* should be reconsidered. A particular focus of the debate was the "necessity" principle employed by this Court to "avoid [] passing upon a large part of all the constitutional questions pressed upon it for decision . . . , notwithstanding conceded jurisdiction, until *necessity* compels it in the performance of *constitutional duty.*"

Rescue Army v. Municipal Court of Los Angeles, 331 U.S. 549, 569 (1947)(emphasis added).

This Court has never set forth, in one place, the full analysis by which to determine when the necessity exists which compels this Court to fulfill its constitutional duty to decide a constitutional issue. By reviewing the duties and limitations imposed upon this Court by the Constitution, its jurisdictional statutes, and prudence, one may discern a clear pattern. This brief sets out this pattern, logically organizing the duties and limitations of this Court into a coherent analysis. This analysis is then applied to determine whether reconsideration of *Roe v. Wade* is constitutionally necessary in the cases at bar.

I. A LOGICAL, COHERENT ANALYSIS GOVERNING THE CONSTITUTIONAL NECESSITY FOR THIS COURT TO DECIDE A CONSTITUTIONAL ISSUE IS DISCERNIBLE FROM PRECEDENT.

A. FOUR ELEMENTS GOVERN THE CONSTITUTIONAL NECESSITY OF DECIDING A CONSTITUTIONAL ISSUE UNDER THIS COURT'S PRECEDENTS.

Four elements govern whether, in a particular case, the decision of a constitutional issue is necessary in the performance of constitutional duty: (1) a constitutional duty to say what the law is, (2) a constitutional limitation of decision opportunities to cases and controversies, (3) a statutory limitation on subject matter jurisdiction, and (4) prudential principles imposed by this Court upon itself for sound jurisprudential reasons.

1. THIS COURT HAS A DUTY TO INTERPRET THE CONSTITUTION.

"It is emphatically the province *and duty* of the judicial department to say what the law is." *Marbury v. Madison*, 1 Cranch 137, 177 (1803)(emphasis added). So declared this Court in the famous case of *Marbury v. Madison*, in which it deter-

mined the Constitution to be the supreme law of the land, governing even enactments of Congress. *Id.* at 177-79. This Court also decided in *Marbury* that it had authority to review actions of other elements of government to determine whether they comported with this Court's declaration of "what the law is" with respect to the Constitution. *Id.*

This Court could most comprehensively fulfill its duty to declare what the law is by publishing its own commentary on the law, in the manner of William Blackstone or Lord Coke. Of course, such a project would be of immense and prohibitive proportions, and no commentary could cover every conceivable issue.

More significantly, however, this Court is prohibited from roaming about the constitutional field in such a manner by its constitutional charter. There are limits placed upon its power and duty to say what the law is, which are set forth in detail below.

However, these limitations must not be employed to avoid deciding matters which this Court has a duty to decide. Professor Gunther has styled as a neo-Brandeisian fallacy the misuse of the "necessity" principles set forth by Justice Brandeis in his concurrence to *Ashwander v. TVA*, 297 U.S. 288, 346-48 (1936)(Brandeis, J., concurring), to support a view that this Court has a general discretion not to adjudicate. *See generally* G. Gunther, *The Subtle Vices of the "Passive Virtues" — A Comment on Principle and Expediency in Judicial Review*, 64 Colum. L. Rev. 1 (1964)(commenting on the content and uses of the *Ashwander* rules). *Cf.* Wechsler, "Toward Neutral Principles of Constitutional Law," in *Principles, Politics, and Fundamental Law (1961).*

The duty to decide, when constitutionally required, is illustrated by Justice Marshall in Marbury, where he felt compelled, in giving a legal justification for his decision, to comment on matters not necessary to the decision of the case but necessary to a legal justification of the case. He wrote:

> The peculiar delicacy of this case, the novelty of some of its circumstances, and the real difficulty attending the points which occur in it, require a complete exposition of the principles on which the opinion to be given by the court is founded.

Marbury, 1 Cranch at 154. To this comment must be added another of Justice Marshall's remarks in the case of *Cohens v. Virginia*, 6 Wheat 264, 404 (1821):

> Questions may occur which we would gladly avoid; but we cannot avoid them. All we can do is to exercise our best judgment and conscientiously to perform our duty.[2]

2. THIS COURT'S DUTY TO INTERPRET THE CONSTITUTION IS LIMITED BY ART!CLE III OF THE CONSTITUTION.

The Constitution of the United States allows this Court to interpret the Constitution only in relation to "Cases . . . arising under this Constitution." U.S. Const. art. III, § 2.

From this limitation arise certain rules, which Justice Brandeis set forth in his concurring opinion to *Ashwander v. TVA*, 297 U.S. at 346-48 (1936)(Brandeis, J., concurring). These rules apply even where jurisdiction is conceded under the controlling jurisdictional statutes, *id.* at 346, for they are constitutionally mandated by Article III.

Justice Brandeis set forth these rules as follows:

First, "[t]he Court will not pass upon the constitutionality of legislation in a friendly, non-adversary, proceeding. *Id.* at 346.

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[2] This brief does not enter into the debate over this Court's discretion to decline the exercise of jurisdiction. It merely addresses the necessity of deciding all elements of a case which are required in giving a legal justification for this Court's decision in a case which is decided by this Court. Your amicus does not believe that the standard of review is an issue which may properly be avoided. It is different in kind from construing a statute to avoid constitutional difficulty or deciding a case on procedural grounds to avoid a constitutional issue.

Second, "[t]he Court will not 'anticipate a question of constitutional law in advance of the necessity of deciding it,'" nor will it "'decide questions of a constitutional nature unless absolutely necessary to a decision of the case.'" *Id.* at 346-47 (citations omitted).[3]

Third, "[t]he Court will not pass upon the validity of a statute upon complaint of one who fails to show that he is injured by its operation." Id. at 347.

Fourth, "[t]he Court will not pass upon the constitutionality of a statute at the instance of one who has availed himself of its benefits." Id. at 348.

3. THIS COURT'S DUTY TO INTERPRET THE CONSTITUTION IS LIMITED BY ITS JURISDICTIONAL STATUTES.

Pursuant to its authority to "ordain and establish" federal courts, U.S. Const. art. III, § 1, Congress has enacted jurisdictional statutes which require a "deprivation, under color of any State law, statute, ordinance, regulation, custom or usage, of any right, privilege or immunity secured by the Constitution of the United States" or a claim "arising under the Constitution, laws, or treaties of the United States" for federal district court jurisdiction. 28 U.S.C. §§ 343(3) and 1331. Without satisfaction of these prerequisites, the cases at bar should not have come before this Court by way of the lower federal courts.[4] Similarly,

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[3] As noted *infra*, the question of establishing the appropriate standard of review is a necessary decision to this Court's constitutional review of a case and not a discretionary matter which may be avoided if convenient.

[4] In addition to establishing the proper standard of review, this Court must also examine its jurisdiction. As noted in text, this Court only has jurisdiction over these cases if there is yet a constitutional right to abortion.

In *Bender v. Williamsport Area School District*, 475 U.S. 534 (1986), this Court declared that "every federal appellate court has a special obligation to 'satisfy itself not only of its own jurisdiction, but also that of the lower courts

(footnote continued)

had these cases come up through state courts, this Court could only have heard them if the statutes at issue were "repugnant to the Constitution" or if a constitutional right were claimed. 28 U.S.C. § 1257.

4. THIS COURT'S DUTY TO INTERPRET THE CONSTITUTION IS LIMITED BY PRUDENTIAL CONSIDERATIONS.

Self-imposed, prudential principles have been developed by this court, based upon policy considerations. These rules were summarized in Justice Brandeis' *Ashwander* concurrence as follows:

First, "[t]he Court will not 'formulate a rule of constitutional law broader than is required by the precise facts to which it is applied.'" *Ashwander*, 297 U.S. at 347 (Brandeis, J., concurring)(citations omitted).

Second, "[t]he Court will not pass upon a constitutional question although properly presented by the record, if there is also present some other ground upon which the case may be disposed of." *Id.*

Third, "'[w]hen the validity of an act of the Congress[5] is drawn in question, and even if a serious doubt of constitutionality is raised, it is a cardinal principle that this Court will first ascertain whether a construction of the statute is fairly possible by which the question may be avoided.'" *Id.* at 348 (citation omitted).

Footnote 4 continued
in a cause under review,' even though the parties are prepared to concede it." *Id.* at 541 (citation omitted). The question of jurisdiction is a "fundamental" one, which "the Court is bound to ask and answer for itself, even when not otherwise suggested, and without respect to the relation of the parties to it." *Bender*, 475 U.S. at 547. Thus, in determining whether subject matter jurisdiction lies in the present case, this Court must carefully consider *Roe*, the case upon which federal jurisdiction rests.

[5] This principle has been extended to acts of state legislatures, as well. *See, e.g., Thornburgh v. American College of Obstetricians and Gynecologists*, 737 F.2d 283, 294 (1984).

B. THESE FOUR ELEMENTS FORM A LOGICAL, SEQUENTIAL ANALYSIS TO BE EMPLOYED IN ANALYZING THE NECESSITY OF DECIDING A CONSTITUTIONAL ISSUE.

These duties and rules may be arranged in logical, sequential order. The result is conceptually similar to a series of increasingly fine filters; the analysis filters cases, then issues, and then grounds of decision at subsequent levels until only those which are properly to be decided remain. The phases of the analysis are as follows:

1. *Is there a case or controversy?* Logic compels that initial consideration be given to the requirements of the Constitution, which authorized creation of this Court and granted it powers within the jurisdiction to be prescribed by Congress. Justice Brandeis' four rules dealing with Article III, set forth above, are properly asked at this point. These questions determine whether a concrete, adversarial context exists for the resolution of constitutional issues. They prevent abstract decisions on hypothetical points.

2. *Is there jurisdiction?* Logic likewise compels that the jurisdictional statutes be next examined. Congress further defined the jurisdiction of this Court and created the lower courts and limited their jurisdiction by these statutes. These statutes require, in part relevant herein, that a suit must be initiated based upon the violation of a constitutional right.

If there is an Article III case and jurisdiction exists, then the case itself is properly before this Court, whether it arrives by grant of a writ of certiorari or by appeal.

3. *Are there prudential reasons for avoiding certain aspects of the case?* At this point, the three prudential rules of Justice Brandeis' *Ashwander* principles must be considered. Is there some statutory or procedural basis for decision by which a constitutional decision may be avoided? May a statute be construed in a manner favoring constitutionality? If a constitutional decision must be made, what are the narrowest possible grounds upon which it may be properly made?

This last question must be asked in light of this Court's duty both to say what the law is by interpreting the Constitution when required and by its judicial duty to give the legal basis for its decision in a reasoned manner. Reasoned exposition of all elements of the analysis which are logically required in order to give an explanation of that legal basis of the decision must be deemed necessary to the decision.

The proper filtering analysis decides first which cases must be heard, then — employing prudential considerations — what issues must be heard, and finally what grounds must logically be given to support the decision. Prudence requires that the fewest possible issues be resolved on the lowest level of grounds required. The required grounds are all those necessary to logically justify the decision. This analytically includes the standard — the constitutional analysis — to be employed. Without such a determination, the decision has not been legally and logically justified.

C. CONSIDERATION OF SOME SPECIFIC QUESTIONS CONCERNING RECONSIDERATION REVEAL THAT RECONSIDERATION OF *ROE v. WADE* IS APPROPRIATE IN THIS CASE.

Finally, some specific questions with regard to reconsideration have arisen in the opinions of this Court. These questions have already been settled and require brief exposition at this point.

First, *must the parties ask for reconsideration?* No. Necessity of reconsideration of a constitutional issue is not determined by whether the parties have requested reconsidera-

tion.[6] Just last term, in *Patterson v. McClean Credit Union*, 109 S.Ct. 2363 (1989), this Court reconsidered *Runyon v. McCrary*, 427 U.S. 160 (1976), without any request from the parties. *Patterson*, 109 S.Ct. at 2380 (Brennan, J., dissenting)("I find it disturbing that the Court has in this case chosen to reconsider, without any request from the parties . . . .").

Second, *is it sufficient for reconsideration if the right created by a prior case is the basis of the claim in a later case?* Yes. This is the basis upon which the Court reconsidered the *Patterson* case. In *Patterson*, the plaintiff brought an action based upon the statutory right created by an interpretation of 42 U.S.C. § 1981 in *Runyon*, 427 U.S. 169, i.e., that § 1981 encompasses a private contract between an employer and employee. It is a more difficult task where a prior case is not as directly implicated as to provide the right upon which the suit is founded. This is evident in *South Carolina v. Gathers*, 109 S.Ct. 2207 (1989), decided by this Court last term. In *Gathers*, Justices O'Connor and Kennedy and Chief Justice Rehnquist, in dissent, decided that the holding of the prior case of *Booth v. Maryland*, 482 U.S. 496 (1987), was not sufficiently implicated for reconsideration of that case. *Id.* at 2212 (O'Connor, J., dissenting, joined by Rehnquist, C.J., and Kennedy, J.). This was so because *Gathers* involved prosecutorial comments about a criminal victim's character in closing argument, not in the submission of evidence which *Booth* forbade. Thus, *Booth* was not sufficiently implicated for Justices O'Connor and Kennedy and Chief Justice Rehnquist to reconsider that case. *Id.* at 2211.

[6] *In Thornburgh v. American College of Obstetricians and Gynecologists*, Justice O'Connor implied that she would not reach the issue of reconsideration of *Roe v. Wade* because the parties had not asked the Court to do so. 106 S.Ct. at 2213. However, in *Akron v. Akron Center for Reproductive Health*, she personally reached the issue of *Roe's* constitutional correctness and declared much of it unconstitutional, despite the fact that the parties had not asked the Court to reconsider *Roe*, a point which she expressly noted. 462 U.S. at 458, 452. Further, in *Webster*, she declared her willingness to reconsider Roe in a proper case.

Justice Scalia would have overruled *Booth*, *id.* at 2217-18, as, apparently, would have Justice White. *Id.* at 2211.

Third, *may this Court decide a case on broader principles than reasonably required by the precise facts of the case before it in appropriate circumstances?* No, but it must resolve a sufficient number of constitutional issues to give a reasoned, legal justification for its decision. This properly includes a decision concerning the standard of review, i.e., in this case, whether or not the analysis of *Roe v. Wade* is still good law. It may also include resolution of other matters not required by a simple judgment of affirmation or reversal which are, however, necessary to give a legal justification for the decision rendered. This question is often erroneously framed as whether a decision may be made on a broader than necessary basis. When "necessary" is properly understood to encompass those matters necessary to giving the required legal justification for a decision, the confusion is resolved. The rule, then, is that no Court should declare a rule of constitutional law broader than required by the precise facts of the case, but that this concept includes matters, such as resolving the appropriate standard of review (even if that requires reconsideration of precedent), necessary to giving a reasoned, legal justification for the decision.[7]

[7] Many examples exist where this Court has decided issues it felt necessary to giving a legal justification for its decision but has been criticized for reaching issues not necessary under the facts of the case. Because all matters necessary to a legal justification of an opinion are required but decision of other matters is not permitted, the question of what matters ought to be addressed in an individual case is one subject to differing judgment. In *City of Richmond*, 109 S.Ct. 706 (1989), Justice O'Connor, writing for the Court, authored an opinion which went beyond the facts to state a set of governing principles — presumably to give legislative bodies guidance in developing the law. *Id.* at 735. This was observed by Justice Marshall, writing for the dissent. *Id.* at 752 (Marshall, J., dissenting)("the majority has gone beyond the facts of this case to announce a set of principles"). In another case from last term, *Perry v. Leeke*, 109 S.Ct. 609 (1989), this Court reached an issue which Justice Kennedy did not feel was necessary to the decision. *Id.* at 602

(footnote continued)

This principle explains Justice Marshall's decision in *Marbury* to comment on matters required for giving a legal justification for the Court's decision. He expressed both his sensitivity to avoiding overbroad decisions and the need to resolve those constitutional issues required for a legal justification of his opinion. In discussing the issue of whether a mandamus could go to the Secretary of State, he wrote, "It may not be proper to mention this position; but I am compelled to do it." *Marbury*, 1 Cranch at 149. He was compelled to do it because of this Court's duty to provide a reasoned, legal justification for its ruling. He commented, "These observations are premised solely for the purpose of rendering more intelligible those which apply more directly to the particular case under consideration." *Id.* at 156.[8]

Footnote 7 continued
("In view of our ruling, it is quite unnecessary to discuss whether prejudice must be shown when the right to counsel is denied. I would not address that issue . . . ."). Other cases where the Court has been accused of deciding more broadly than the precise facts required are *Daniels v. Williams*, 474 U.S. 327 (1986); *Illinois v. Gates*, 462 U.S. 213 (1983); *Michelin Tire Corp. v. Wages*, 423 U.S. 276 (1976); *Pointer v. Texas*, 380 U.S. 400 (1965); and *Mapp v. Ohio*, 367 U.S. 643 (1961). The Court has even expressly acknowledged its broader than strictly required holding in some cases, such as *Commonwealth Edison Co. v. Montana*, 453 U.S. 609 (1981), and *Perez v. Campbell*, 402 U.S. 637 (1971).

Acknowledging that resolution of all issues necessary to a reasoned legal justification of this Court's decision is required but that going beyond that is forbidden resolves the tension between the practice of this Court in the cases above and its rule against overly broad decisions.

[8] Much debate has raged over Justice Marshall's decision, *see e.g.*, Van Alstyne, *A Critical Guide to Marbury v. Madison*, 1969 Duke L.J. 1, including the criticism that, given its conclusion, the Court should have said only that it lacked jurisdiction. Much of what was said in the early part of the opinion, regarding the propriety of issuing mandamus against an executive's illegal acts, might be characterized as *obiter dictum*. Indeed, Thomas Jefferson, the contemporary President and a key player in the *Marbury* drama, insisted throughout his life that most of *Marbury* was "merely an obiter dissertation of the Chief Justice." *Jefferson to Justice William Johnson, June*

(footnote continued)

I. THE FAILURE OF THIS COURT TO AGREE UPON AND FOLLOW SUCH AN ANALYSIS CONCERNING RECONSIDERATION HAS INTRODUCED CHAOS INTO THE LAW AND INTO THIS COURT.

The disagreement on this Court over the analysis to be applied with regard to reconsideration of precedent is evident in three cases from last term where reconsideration was considered and treated in three different ways. The chaotic results which flow from this failure to agree on an analysis are illustrated by two abortion cases, *Roe v. Wade* and *Webster v. Reproductive Health Services*. The former overreached, causing this Court in *Akron* to overrule part of that decision. The latter underreached, creating chaos in abortion law. Either approach is wrong, both for sound jurisprudential reasons and because of the illicit results.

A. THAT THIS COURT HAS NOT AGREED UPON AN ANALYSIS FOR RECONSIDERATION IS EVIDENT FROM THIS PAST TERM.

In this past term, this Court considered three key cases in which reconsideration was proposed. The inconsistent manner in which these were handled reveals the lack of an agreed analysis for reconsideration.

In the first case, *Patterson v. McClean Credit Union*, 109 S.Ct. 2363, this Court plenarily reconsidered *Runyon v. McCrary*, 427 U.S. 160. There was no disagreement among the majority over whether reconsideration should occur, although, as noted *supra*, neither party asked for reconsideration and the sole implication of the prior decision was that it created the right under which the action was brought.

Footnote 8 continued
12, 1823, 1 S. Car. His. & Gen. Mag. 1, 9-10 (1900). Justice Marshall himself later called some of his statements about Article III in *Marbury* unduly broad and partially rejected them in *Cohens v. Virginia*, 6 Wheat 264 (1821). Nonetheless, the fact that he may have erred by going somewhat beyond what was required to give a legal justification for his decision does not vitiate the principle. His error, if any, was of degree and not of principle.

In the second case, *Webster v. Reproductive Health Services*, 109 S.Ct. 3040, the members of the majority could not agree that reconsideration was proper even though *Roe v. Wade* created the right under which the action was brought. And such reconsideration as was called for was not plenary, with the exception of that proposed by Justice Scalia. The plurality declared that only the trimester scheme was implicated and Justice O'Connor thought that nothing of Roe was implicated.[9]

As argued in this brief, however, distinguishing the degrees of implication of a seminal case — one which creates the right or analysis under which the cause of action arose — is unnecessary. Such a case is always fully implicated in a cause which invokes that right or analysis. Such distinguishing of degrees of implication was not engaged in in *Patterson*, nor is it appropriate under the principle that the decision of all matters necessary to a reasoned justification of the Court's decision — including establishment of the standard of review — is constitutionally necessary. The result of the failure of this Court to employ a consistent analysis with regard to reconsideration resulted in turmoil and confusion in abortion jurisprudence, as more fully set forth *infra*. It further resulted in the failure of a majority of this Court to address a decision, *Roe*, which five Justices have declared to be constitutionally flawed.

In the third case, *South Carolina v. Gathers*, 109 S.Ct. 2207 (1989), the very decision-making process of the potential working majority in that case was disrupted by its inability to agree on an analysis regarding reconsideration. It is apparent from the opinions in Gathers that five Justices of this Court believe that *Booth v. Maryland*, 482 U.S. 496 (1987) — the case which created the right of criminals not to have evidence of their

[9] It must be noted that Justice O'Connor viewed the Missouri statute as not inconsistent with *Roe* or its progeny because it did not "unduly burden" the abortion right. However, this unduly burdensome or "absolute obstacle" test, championed in *Akron* by Justice O'Connor, and under which she would have upheld the ordinances at issue in *Akron*, was expressly rejected by this Court as violative of *Roe v. Wade*. *Akron*, 462 U.S. at 420 n.1.

victim's character introduced at trial — was wrongly decided. The result, however, was the extension of the reach of *Booth v. Maryland* to prosecutorial statements about the victim's character.

While judicial restraint is admirable and required by sound, constitutional jurisprudence, it is improperly applied to avoid considering the precedent which creates the foundational right upon which a cause is brought. Consideration of that foundational right, and the case creating it, is essential in giving a reasoned, legal justification for this Court's decision in any case based upon that right. The havoc wrought by this Court's failure to consistently apply the sort of analysis proposed herein is further illustrated in two cases, *Roe* and *Webster*.

B. *ROE v. WADE* DEMONSTRATES THE OVERREACHING POSSIBLE WITH AN INADEQUATE ANALYSIS AND THE RESULTANT OVERRULING REQUIRED.

Roe demonstrates both the matters necessary to deciding a constitutional issue and the perils in deciding those that are not necessary.[10] The *Roe* majority correctly began by establishing the proper standard of review, to which it devoted the majority of the opinion. Given its judgment that the Texas criminal abortion statute — excepting only cases of risk to maternal life — was unconstitutional, the Court needed to decide the issues necessary to give a reasoned, legal justification of its decision. To merely strike down the Texas statute, without explanation, would not have fulfilled this Court's constitutional duty to declare what the Constitution means when deciding the case.[11]

[10] This, of course, in no way concedes any correctness as to the substantive holdings of the *Roe* Court.

would not have fulfilled this Court's constitutional duty to declare what the Constitution means when deciding the case.[11]

Necessary to a reasoned, legal justification of this Court's decision in *Roe* was its holding that there is a fundamental right to abortion. Likewise, a holding that no compelling interests extended throughout pregnancy was vital to the analysis. *Roe* also demonstrated proper restraint in not deciding the issues of paternal rights and parental rights (of parents with minors seeking abortion). *Roe*, 410 U.S. at 165 n.67. Deciding these issues, which were not presented by the facts, would have decided constitutional questions in advance of the necessity of doing so. In Article III terms, no case existed with respect to these matters, and, therefore, this Court was without constitutional authority to decide them.

Unnecessary to a reasoned, legal justification of the decision in *Roe* was creation of the trimester scheme. Also unnecessary were the inherently legislative declarations, such as the statement that a hospitalization requirement for post-first-trimester abortions was constitutionally permissible. The Court reached these issues in advance of the necessity of deciding them, violating Article III, and it decided matters more broadly than required by the facts, violating prudence. The *Roe* majority ought to have awaited another case involving a viability line to reach a discussion of viability. It should have decided the maternal health line in a case properly presenting that issue, such as a case requiring hospitalization for abortions after a certain point.

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[11] Of course, this Court has the power to summarily affirm or reverse decisions in appropriate circumstances. However, constant reliance on such a practice would not comport with this Court's duty to decide. Practically, such a practice would also unduly prolong the trial and error, see-saw interaction between this Court and the legislatures in their attempt to pass constitutional legislation. Such considerations, however, do not justify overreaching beyond what is necessary to give a reasoned, legal justification of a decision.

The imprudence of such premature decision-making was demonstrated in the progeny of *Roe*, especially in the case of *Akron v. Akron Center for Reproductive Health*. 462 U.S. 416 (1983). In *Akron*, the majority found it necessary both to alter the trimester scheme, precipitously created in *Roe*, and to reject a post-first trimester hospitalization requirement, prematurely approved in *Roe*. *Akron*, 462 U.S. at 435-47.[12]

Thus, *Roe* well illustrates how a court may begin correctly and then go astray by overreaching. A proper analysis would preclude such overreaching.

C. *WEBSTER* DEMONSTRATES THE UNDERREACHING POSSIBLE WITH AN INADEQUATE ANALYSIS AND THE RESULTANT CHAOS ATTENDING SUCH ACTION.

By contrast with *Roe*, the *Webster* amalgam of opinions did not even begin correctly. Neglected was the essential first step in constitutional analysis, the determination of the standard of review — the constitutional analysis — to be employed in reviewing the statutes at issue. The core issue in any constitutional challenge to a statute is whether the statute comports with the Constitution — not whether it complies with a prior decision of this Court. Deciding whether a statute conforms to the requirements of some precedent is but a shorthand way of asking whether constitutional requirements are met. Therefore, it is essential to the analysis to determine what the Constitution requires. In a matter already decided, this question is answered by citation to precedent, the principles of which are applied to the new fact situation. But in each subsequent case, the question of what the Constitution requires must be asked. It may be simply answered by reaffirmation of the precedent, either express or implicit, but it must be

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[12] *See* Bopp & Coleson, *The Right to Abortion: Anomalous, Absolute, and Ripe for Reversal*, 181 B.Y.U. J. Pub. L. 181, 202-07 (1989)(discussing this disregard of stare decisis at length).

answered. The Constitution is at issue in constitutional adjudication.

Therefore, in *Webster*, the constitutionality of *Roe v. Wade*, *was* before this Court. It could not properly be avoided. The standard of review, by which the Constitution is applied to determine the constitutionality of a statute, must be decided. It is not of a nature permitting avoidance until some more convenient time or some greater implication. If a case is brought to declare a statute unconstitutional on the basis of the decision establishing the right and setting forth the analysis, then that case is implicated. Once implicated, it must be applied, modified, or overruled; its reconsideration is then proper. A state need not reenact the Texas statute struck down in *Roe* before this Court may properly reconsider *Roe*.

Deciding the standard of review as a necessary first step in constitutional analysis is something one may not avoid by prudential principles. It is inherent in constitutional review. It is the very essence of constitutional review, serving as the link between the statutes reviewed and the Constitution. It is not of the same nature as a constitutional challenge to a statute which may be avoided by a permissible construction of the statute. Nor is it of the same nature as a constitutional challenge to a statute which may be avoided by deciding a matter on a statutory, procedural, or independent state law basis. The issue of the correct standard of review arises *precisely when the Court has been unable to avoid a constitutional question and must determine whether a statute is constitutional*. It is *inherently necessary* to decide in the discharge of this Court's constitutional duty and may not properly be avoided.

Therefore, *Webster* underreached — the Court did not fulfill its duty to say what the law is in justifying its decision. The resulting chaos demonstrates clearly why strict adherence to a sound analysis with regard to deciding constitutional matters, and especially the standard of review, is essential to sound constitutional adjudication. Indeed, the chaos created by *Webster* alone is sufficient to call this Court to say what the law is in the cases at bar.

The confusion resulting from *Webster* may be seen in the varying interpretations given to the opinion, which run along a spectrum from a *sub silentio* reversal of *Roe*, to a *sub silentio* reversal of the trimester scheme and this Court's most recent pronouncements in *Akron* and *Thornburgh*, to a mere funding case with few other implications. In light of such diversity of possibilities, how may the legislatures act? What is permitted?

One may of course say that nothing was overruled in *Webster*, for the Court used no such language. However, the notion of *sub silentio* reversal is a commonplace in the law. And is the meaning of a case circumscribed by its proper holding? The legitimate holding of *Roe* — if legitimacy be limited to that permitted by the narrowest holding based upon the specific facts — was but the tip of the iceberg which comprised the full meaning of *Roe* for abortion jurisprudence.

Justice Oliver Wendell Holmes declared that the state of the law is nothing more than a prediction of what a court will do at a given time with a given set of facts. Holmes, *The Path of the Law*, 10 Harv. L. Rev. 457 (1897). Employing this analysis of legal realism, the meaning of *Webster* may be determined by examining the statements of various Justices, both in *Webster* and before, to determine what elements of abortion jurisprudence yet enjoy majority support. The result of such analysis raises significant questions.

1. IS THE *ROE* TRIMESTER SCHEME OVERRULED *SUB SILENTIO?*

It appears from the opinions in *Webster* that majority support for the trimester scheme of *Roe* has disappeared. Justice O'Connor declared her belief that a state has a compelling interest in unborn life and maternal health throughout pregnancy in her earlier dissents to *Akron* and *Thornburgh*. *Thornburgh*, 476 U.S. at 828 (O'Connor, J., dissenting)("I . . . remain of the views expressed in my dissent in *Akron*. The State has

compelling interests in ensuring maternal health and in protecting potential human life . . . throughout pregnancy."). With Chief Justice Rehnquist and Justices White, Scalia[13], and Kennedy saying the same thing in *Webster*, it is readily apparent that a majority of this Court has now recognized these two interests as existing throughout pregnancy, indicating the demise of the trimester scheme. *Webster*, 109 S.Ct. at 3057.

But this Court has not stated this demise in express language. Will legislatures feel free to act upon it? By comparison with the small area of the law this Court settled in *Webster*, the areas it unsettled are immense, going to the core of *Roe v. Wade*.

2. IS THE ABORTION RIGHT NOW A LIBERTY INTEREST?

Similarly, the very nature of a woman's interest in choosing abortion is now unclear. In *Roe*, this Court determined that a woman has a fundamental right to choose abortion, employing a substantive due process analysis. The *Webster* plurality declared that a woman has only a "liberty interest" in abortion under the Due Process Clause of the Fourteenth Amendment. *Webster*, 109 S.Ct. at 3058. Justice O'Connor, with her advocacy of the rational basis standard of review in most cases, agrees that there is no general, fundamental right to abortion. *Akron*, 462 U.S. at 453 (O'Connor, J., dissenting). However, where there is an undue burden, she might find a fundamental right, evidenced by her requiring a compelling state interest to justify regulation of abortion in such cases. *Id.* Thus, there is now a majority of the Court which no longer believes that there is a general fundamental right to abortion. But what is the law? What does the Constitution require?

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[13] As Justice Scalia would reverse *Roe*, it is assumed that, to the extent a fundamental right to abortion is given continued recognition, he would agree that there are offsetting compelling interests in maternal health and unborn life.

3. IS *AKRON* OVERRULED *SUB SILENTIO* BY REHABILITATION OF THE UNDULY BURDENSOME TEST?

In *Akron*, this Court found the unduly burdensome test to be an unconstitutional form of analysis, forbidden by the dictates of *Roe v. Wade* itself. *Akron*, 462 U.S. at 420 n.1. Logically then, any invocation of, or reliance upon, the unduly burdensome test would be in direct derogation of *Roe*. However, in *Webster*, Justice O'Connor readily relied upon this analysis to uphold the statutes at issue in *Webster* and to declare that all of the Missouri statute could be upheld under prior decisions of this Court, at the same time arguing that no prior abortion decision of this Court was sufficiently implicated for purposes of reconsideration. *Webster*, 109 S.Ct. at 3060. At a very minimum, however, the resurrection of the unduly burdensome test implicated *Akron*, directly rejecting a key holding of that decision.

Is the unduly burdensome test — as the lowest common denominator of the current majority on abortion issues — the proper analysis to be employed by lower courts and legislatures? If *Akron* is indeed overruled *sub silentio*, is legislation such as that found in *Akron* and in *Thornburgh* now constitutional?

A further problem arises if Justice O'Connor's lowest-common-denominator analysis is now the *de facto* analysis for review of abortion legislation. It has been generally thought since *Roe* that the fundamental rights analysis required the showing (1) that the state has a compelling interest and (2) that the legislation enacted is narrowly tailored to effect only the compelling interest. *Roe*, 410 U.S. at 155. But Justice O'Connor wrote in *Akron:*

> The Court has never required that state regulation that burdens the abortion decision be 'narrowly tailored' to express only the relevant state interest. In Roe, the Court mentioned 'narrowly drawn' legislative enactments, but the Court never actually adopted this standard in the Roe analy-

> sis. In its decision today, the Court fully endorsed the Roe requirement that a burdensome health regulation, or as the Court appears to call it, a 'significant obstacle' be 'reasonably related' to the state compelling interest. The Court recognizes that '[a] state necessarily must have latitude in adopting regulations of general applicability in this sensitive area.'

Akron, 462 U.S. at 467 n.11 (O'Connor, J., dissenting)(citations omitted and case names not italicized in original). Which standard must abortion legislation now meet — must it be narrowly tailored or rationally related to a compelling interest?

In sum, *Webster* has thrown abortion jurisprudence into disarray. The very core analysis of *Roe* has been placed in question: as to the nature of the interest, as to the standard of review, as to the temporal extent of the states' compelling interests, and as to the second prong of the *Roe* analysis for legislation burdening (unduly or not?) a fundamental right — if indeed, there is yet a fundamental right. And if the unduly burdensome test controls, what does unduly mean? This chaos alone compels this Court to perform its constitutional duty, which it avoided in *Webster* but which exists in these cases, to say what the law is.

III. EMPLOYING THE PROPER ANALYSIS TO THE ISSUE OF RECONSIDERATION HEREIN REVEALS THAT *ROE v. WADE* SHOULD BE RECONSIDERED IN THESE CASES.

A. THIS COURT SHOULD GO THROUGH THE FULL ANALYSIS TO DETERMINE WHAT ISSUES SHOULD BE DECIDED AND ON WHAT GROUNDS.

It is beyond the scope of this brief — which addresses reconsideration of *Roe v. Wade* — to apply the analysis herein in all of its respects to the statutes at bar. This Court should take this opportunity to employ a systematic approach to determine what issues should be decided and on what grounds. However,

if this Court decides to consider the constitutionality of any part of the statutes at issue herein, i.e., it finds that it cannot avoid them by decisions on other than a Constitutional basis, then it should reconsider *Roe*, which is the nexus between the Constitution and the statutes. *Roe v. Wade*, as both the source of both the right and analysis to be employed in constitutional review is clearly implicated for purposes of reconsideration.

B. THE ISSUE OF RECONSIDERATION ITSELF IS NOT ONE WHICH THIS COURT MAY AVOID IF IT CHOOSES TO DECIDE THESE CASES AND ISSUE A WRITTEN OPINION BECAUSE *ROE* AND ITS RIGHT AND ANALYSIS ARE CLEARLY IMPLICATED.

In giving a reasoned, legal justification for any decision reached in these cases, the Court must set forth the proper constitutional analysis to be employed. This requires reconsideration of *Roe v. Wade*. It is inherent in the analysis as discussed at length above.

Moreover, although further "implication" is not required, it is certainly present in these cases. These cases more directly implicate *Roe*, in terms of involving more of its analysis and affecting more periods of pregnancy, than did *Webster*. Unlike *Webster*, which largely involved funding matters (already settled in principle by this Court) and regulation after viability (where compelling state interests exist even under *Roe)*, the cases at bar implicate three key elements of *Roe*, the compelling interests in unborn life and maternal health throughout pregnancy, the right to effectuate the abortion decision, and the right to make the abortion decision in consultation with one's physician. The statutes at issue in these cases, therefore, directly impinge upon the right to abortion created in *Roe* to an even greater extent than in *Webster*.

1. COMPELLING STATE INTERESTS IN MATERNAL HEALTH AND UNBORN LIFE, WHICH UNDERLIE THESE STATUTES, ARE ASSERTED THROUGHOUT PREGNANCY.

Underlying the Minnesota parental notice statute at issue in *Hodgson* are compelling state interests in unborn human life and in protecting traditional family authority and vulnerable minors. Indeed, the Minnesota parental notice statute has had the demonstrated effect of reducing the adolescent abortion rate — dramatically furthering the State's compelling interest in protecting unborn human life.[14] Yet this statute applies throughout pregnancy, not just after viability.

Furthermore, underlying the Illinois clinic statute at issue in *Turnock* are the State's compelling interests in maternal health and in unborn life. These likewise apply throughout pregnancy. The State's compelling in protecting maternal health is the

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[14] Statistics from the Minnesota Department of Health indicate that in Minnesota during 1975-80, before the parental notice statute went into affect, minors showed the following annual patterns:

1. Pregnancies increased from 4142 to 4360 = an increase of 5%.

2. Births decreased from 2494 to 2033 = a decrease of 19%.

3. Abortions increased from 1648 to 2327 = an increase of 41%.

In the period from 1981-86, following enactment of the statute the following patterns emerged:

1. Pregnancies decreased from 4360 to 3171 = a decrease of 27%.

2. Births decreased from 2033 to 1626 = a decrease of 20%.

3. Abortions decreased from 2327 to 1545 = a decrease of 34%.

Data from Minnesota Department of Health (adjusted for population fluctuation).

There is no evidence that this dramatic drop in the abortion rate resulted from teens leaving the state to obtain abortions. Blum, Resnick & Stark, *The Impact of Parental Notification Law on Adolescent Abortion Decision-Making*, 77 AJPH 619, 620 (1987).

principle justification of this regulatory scheme. The State's interest in protecting unborn life, however, is also advanced by the provision requiring counseling concerning alternatives to abortion. Ill. Rev. Stat. ch. 111 1/2, para. 205.730(b)(3). This counseling is intended, in part, and has the effect, to cause women to more seriously consider alternatives to abortion, thereby decreasing the number of abortions. Unborn lives are thereby saved.

Thus, for purposes of reconsideration, the holdings of *Roe* that the state's compelling interests in maternal health only arise after the first trimester and in unborn life after viability are squarely contradicted. In contrast, *Webster* involved only the State's compelling interest in unborn life after viability.

2. THE RIGHT TO EFFECTUATE THE ABORTION DECISION IS IMPLICATED.

The right to effectuate the abortion decision is also guaranteed by the decisions of this Court. *Roe*, 410 U.S. at 163. Under the Illinois statute at issue in *Turnock*, first trimester abortion clinics are thoroughly regulated. This again implicates a key holding of *Roe* that regulation of the abortion decision and its effectuation must be left to the woman and her physician in the first trimester. After that, regulation is only permitted for protection of the woman's health. In this case, it is asserted that such regulations are not indicated for the protection of maternal health, and, in any event, these regulations extend into the forbidden zone of the first trimester. For purposes of reconsideration, *Roe* is sufficiently implicated.

3. THE RIGHT TO CONSULT ONE'S PHYSICIAN IN MAKING THE ABORTION DECISION IS FORBIDDEN.

Finally, a direct and absolute bar to one of *Roe's* key elements is present in the Illinois provision (at issue in *Turnock*) which prevents anyone with a monetary interest in the performance of the abortion decision from counseling a woman concerning her abortion decision. Ill. Rev. Stat. ch. 111 1/2, para.

205.730(b)(2)(D). As interpreted by the lower courts, this provision directly conflicts with *Roe*'s provision that a woman is free to make her abortion decision "in consultation with her physician," *Roe*, 410 U.S. at 163, because it forbids this consultation. A key holding of *Roe* is therefore implicated, which justifies reconsideration of that case.

In sum, this Court ought to reconsider *Roe v. Wade* if it decides any constitutional issue in this case; because establishing the standard of review and confirming the right under which the case is brought are essential to the analysis of constitutionality; because explication of the standard of review is necessary to providing a reasoned, legal justification for the judgment; and because key aspects of *Roe* are implicated by the statutes themselves.

CONCLUSION

For the reasons given herein, this Court should reconsider *Roe v. Wade* in its consideration of the cases at bar. Upon reconsideration, this Court should determine that the doctrine of stare decisis does not preclude the reversal of *Roe v. Wade*,[15] *that, under the correct test for fundamentality,*[16] *there is no fundamental right to abortion in the history and tradition of our nation,*[17] *and that, therefore, Roe v. Wade* should be reversed.

Respectfully submitted,

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[15] *See* Brief Amici Curiae of the Hon. Christopher H. Smith, Alan B. Mollohan, Vin Weber, Robert K. Dornan, Earl Hutto, John La Falce, Virginia Smith, Bill Emerson, Henry H. Hyde, and Gordon J. Humphrey, Members of the Congress of United States, in Support of Appellants in *Turnock* and Cross-Petitioners in *Hodgson*.

[16] *See* Brief Amicus Curiae of Free Speech Advocates in Support of Appellants in *Turnock v. Ragsdale*.

[17] *See* Brief Amicus Curiae of the American Academy of Medical Ethics in Support of Appellants in *Turnock* and in Support of Cross-Petitioners in *Hodgson*.

AMICUS CURIAE

BRIEF

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No. 88-790

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

BERNARD J. TURNOCK, M.D., M.P.H., et al., ---------- Appellants,

versus

RICHARD M. RAGSDALE, M.D., et al., --- Appellees.

ON APPEAL FROM THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF OF CATHOLICS UNITED FOR LIFE, ORTHODOX CHRISTIANS FOR LIFE, NATIONAL ORGANIZATION OF EPISCOPALIANS FOR LIFE, PRESBYTERIANS PRO-LIFE, SOUTHERN BAPTISTS FOR LIFE, AMERICAN BAPTIST FRIENDS OF LIFE, BAPTISTS FOR LIFE, LUTHERANS FOR LIFE, WELS LUTHERANS FOR LIFE, MORAVIANS FOR LIFE, UNITED CHURCH OF CHRIST FRIENDS FOR LIFE, TASK FORCE OF UNITED METHODISTS ON ABORTION AND SEXUALITY, AND THE CHRISTIAN ACTION COUNCIL AS AMICI CURIAE IN SUPPORT OF APPELLANTS

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TABLE OF CONTENTS

PAGE

TABLE OF CONTENTS i
TABLE OF AUTHORITIES ii
INTEREST OF AMICI v
SUMMARY OF ARGUMENT 1
ARGUMENT 3
I. The Burden of Proof Rests Upon Those Who Would Exclude Unborn Children From The Meaning of the Term "Person" Under the Fourteenth Amendment. 3
II. There Is No Justification for Excluding From the Term "Person" the Class of Human Beings Conceived But Not Yet Born. 5
A. *Roe v. Wade* Gave No Valid Basis for Creating an Exception for Unborn Children. 5
1.Alleged absence of precedent 5
2.Postnatal application of other constitutional provisions 6
3.Apparent inconsistency of state anti-abortion laws with personhood of unborn children 7
4.Alleged laxity of nineteenth century abortion laws 8
B. No Other Basis Exists For Creating an Exception for Unborn Children. 10
1.The framers of the fourteenth amendment did not distinguish between "human beings" and "persons." 10
2.Science rejects the exclusion of unborn children from the class of human beings. 12
3.Logic militates against the creation of an exception for unborn children in the term "person." . . . 14
4.Legal consistency would not be served by the exclusion of unborn children from the protection of the fourteenth amendment. 18
5.Justice demands the inclusion of unborn children within the term "person." 20
III. The Personhood of the Unborn Requires the Rejection of Appellees' Attack Upon the Illinois Statutes and Regulations. 22
CONCLUSION 24

TABLE OF AUTHORITIES

Cases

Betts v. Brady, 316 U.S. 455 (1942) 22
Bonbrest v. Kotz, 65 F. Supp. 138 (D.D.C. 1946) 19
Boyd v. United States, 116 U.S. 616 (1886) 4
Brown v. Board of Education, 347 U.S. 483 (1954) (*Brown I*) 8, 24
Brown v. Board of Education, 349 U.S. 294 (1955) (*Brown II*) 8, 24
City of Akron v. Akron Center for Reprod. Health, Inc., 462 U.S. 416 (1983) 16
Corkey v. Edwards, 322 F. Supp. 1248 (W.D.N.C. 1971), *vacated*, 410 U.S. 950 (1973) 14
DeShaney v. Winnebago County Department of Social Services, 109 S. Ct. 998 (1989) 23, 24
Furman v. Georgia, 408 U.S. 238 (1972) 21
Gideon v. Wainwright, 372 U.S. 335 (1963) 22
Hamby v. McDaniel, 559 S.W.2d 774 (Tenn. 1977) 19
Keeler v. Superior Court, 2 Cal. 3d 619, 470P.2d 617, 87 Cal. Rptr. 481 (1970) (en banc) 18
Legal Tender Cases, 79 U.S. (12 Wall.) 457 (1870) 4
Levy v. Louisiana, 391 U.S. 68 (1968) 4
Michael H. v. Gerald D., 109 S. Ct. 2333 (1989) 23
Michael M. v. Superior Court, 450 U.S. 464 (1981) 7
Planned Parenthood Ass'n of Kansas City, Mo. v. Ashcroft, 462 U.S. 476 (1983) 14
Poe v. Ullman, 367 U.S. 497 (1961) 21
Presley v. Newport Hosp., 117 R.I. 177, 365 A.2d 748 (1976) 14, 16, 19
Roe v. Wade, 410 U.S. 113 (1973) . . . . . 1, passim
Rosen v. Louisiana State Bd. of Medical Examiners, 318 F. Supp. 1217 (E.D. La. 1970), *vacated*, 412 U.S. 902 (1973) 14, 21
Steinberg v. Brown, 321 F. Supp. 741(N.D. Ohio 1970) 5, 6, 14
Thellusson v. Woodford, 31 Eng. Rep. 117 (Ch. 1798) 6
Thornburgh v. American College of Obstets. & Gynecs., 476 U.S. 747 (1986) 13, 15, 17, 23
United States v. Salerno, 481 U.S. 739 (1987) 24

Webster v. Reproductive Health Services, 109 S. Ct. 3040 (1989) 16
West Virginia Board of Education v. Barnette, 319 U.S. 624 (1943) 22

Constitutional, Statutory & Regulatory Provisions

Cal. Penal Code § 187 (West 1988) 19
Ill. Admin. Code tit. 77, § 205.120(b)(9)(F) 24
Ill. Admin. Code tit. 77, § 205.520(b)(3) 24
Ill. Admin. Code tit. 77, § 205.710 24
Ill. Admin. Code tit. 77, § 205.730(a) 24
Ill.Admin. Code tit. 77, § 205.740 24
Ill. Admin. Code tit. 77, § 205.760 24
Ill. Ann. Stat. ch. 38, paras. 9-1.2, 9-2.1, 9-3.2 (Smith-Hurd Supp. 1989) 19
Ill. Ann. Stat. ch. 111 1/2, para. 157-8.3(A) (Smith-Hurd Supp. 1989) 24
Ill. Ann. Stat. ch. 111 1/2, para. 157-8.6-1 (Smith-Hurd 1988) 24
La. Rev. Stat. Ann. § 14:2(7) (West 1986) 19
Minn. Stat. Ann. § 609.2661-609.2665, 609.268 (West 1987) 19
N.D. Cent. Code § 12.1-17.1-02 to 12.1-17.1-04 (Supp. 1989) 19
Tenn. Code Ann. § 20-5-106 (1980) 19
U.S. Const. art. I, § 2, cl. 2 6
U.S. Const. art. I, § 3, cl. 3 6
U.S. Const. art. I, § 9, cl. 1 6
U.S. Const. amend. IV 6
U.S. Const. amend. V 5, 6, 7, 11
U.S. Const. amend. XIII 10
U.S. Const. amend. XIV, § 1 . . . . . 1, passim

Other Authorities

Annotation, *Homicide Based on Killing of Unborn Child*, 40 A.L.R.3d 444 (1971) 18
Annotation, *Liability for Prenatal Injuries*, 40 A.L.R.3d 1222 (1971) 19

Annotation, *Right to Maintain Action or to Recover Damages for Death of Unborn Child*, 84 A.L.R.3d 411 (1978) 19
L. Arey, *Developmental Anatomy* (7th ed. 1974) 14
Cong. Globe, 35th Cong., 1st Sess. App. 65-66 (1858) 12
Cong. Globe, 37th Cong., 2d Sess. 1449 (1862) 11
Cong. Globe, 37th Cong., 2d Sess. 1640 (1862) 22
Cong. Globe, 38th Cong., 1st Sess. 1753 (1864) 11
Cong. Globe, 39th Cong., 1st Sess. 74 (1865) 11
Cong. Globe, 39th Cong., 1st Sess. (1866) 11, 12
Cong. Globe, 40th Cong., 1st Sess. 542 (1867) 11
Cong. Globe, 42nd Cong., 1st Sess. App. 229 (1871) 15
3 Cong. Rec. 1794 (1875) 12
Declaration of Independence para. 2 (U.S. 1776) 22
Dellapenna, "Abortion and the Law," in *Abortion and the Constitution* 137 (D. Horan, E. Grant & P. Cunningham eds. 1987) 9, 10
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The Human Life Bill: Hearings on S.158 Before the Subcomm. on Separation of Powers of the Senate Comm. on the Judiciary, 97th Cong., 1st Sess. 14, 16, 17 (1982) 13
H. Storer, *Criminal Abortion in America* (1860) 6, 19
13 Transactions of the American Medical Association 41-42 (1860) 19

INTEREST OF AMICI

Catholics United for Life

Catholics United for Life (CUL) is the pro-life apostolate of the St. Martin de Porres Dominican Community. Formed in 1974, CUL has twenty-three affiliates across the country, and promotes sidewalk counseling, a technique it developed for saving babies from abortion. Sidewalk counselors work to save each individual baby threatened by abortion -- through prayer, persuasion, offers of assistance, and distribution of literature. CUL also supplies literature on a national level to promote respect for all human life.

Orthodox Christians for Life

Orthodox Christians for Life is a religious-educational prolife organization consisting of members from all jurisdictions of the Eastern Orthodox Church in the United States and Canada. It was founded and functions in a spirit of synergistic cooperation with the hierarchy, clergy, and laity of the Orthodox Church regardless of jurisdiction or geographical location. The organization supports the doctrines and canons of the Church. Its activities have included the recent coordination and creation of an Amicus Brief submitted to the United States Supreme Court on behalf of the Holy Orthodox Church in *Webster v. Reproductive Health Services* (No. 88-605).

In its moral teachings, the Orthodox Church has had a long and continuous history of outspoken condemnation of abortion which dates back to Apostolic times. In fact, the humanity of the unborn child, his "personhood," and his possession of a soul from the moment of conception have been universally understood in the Eastern Church from the earliest times; these understandings remain unchanged and unchallenged in Orthodox theology to this day.

The Holy Orthodox Church remains a unique witness to historical Christianity's understanding of the sacredness of human life: that the unborn are indeed "persons" and that abortion is considered an act of premeditated murder. Orthodox Christians for Life supports and advocates these historical positions and promotes them not only to the faithful, but to the secular culture at large.

National Organization of Episcopalians for Life

National Organization of Episcopalians for Life Research and Education Foundation, Inc. (NOEL), a non-profit Maryland corporation with national offices in Fairfax, Virginia, is a general organization of the Episcopal Church. NOEL's purposes affirm the sacredness and the right to life of all human beings from conception to natural death. NOEL supports the 1988 General Convention Resolution of the Episcopal Church which "emphatically oppose[s] abortion as a means of birth control, family planning, sex selection or any reason of mere convenience," promotes alternatives to abortion, including adoption, and assists those faced with problem pregnancies through its 92 chapters in 32 states.

Presbyterians Pro-Life

Presbyterians Pro-Life is organized under the rules of the Book of Order of the Presbyterian Church (USA), a denomination with three million members. Its objectives are to proclaim the Church's obligation to protect all innocent human life from conception to natural death and to support women in crisis pregnancies by offering alternatives to abortion. It is governed by a board of directors of thirty lay men and women and pastors, all members of the Presbysterian Church (USA). It has a network of local chapters throughout the denomination and publishes a quarterly newsletter that reaches 15,000 individuals and churches.

Southern Baptists for Life

Southern Baptists for Life (SBL) is a pro-life advocacy organization, incorporated in the State of Missouri as a non-profit corporation. SBL was established for the purpose of helping Southern Baptists take a firm, visible, and active stand against abortion, infanticide, and euthanasia. SBL concurs fully with the resolution on abortion passed at the 1982 Southern Baptist Convention, "... that all human life, both born and preborn, is sacred." SBL is governed by a six member board of directors and a fifteen member advisory board and provides pro-life resources to thirty-seven thousand Southern Baptist churches.

American Baptist Friends of Life

American Baptist Friends of Life is a pro-life advocacy organization within the American Baptist Churches/USA, representing the pro-life position of a large percentage of American Baptists. Directed by an eight member executive committee, it publishes a regular newsletter and is taking leadership in the implementation of its new denominational resolution on abortion passed in June of 1988 which states, "as American Baptists, we oppose abortion as a means of avoiding responsibility for conception."

Baptists for Life

Baptists for Life is a Christian pro-life organization representing independent Baptist Churches throughout the United States with main offices in Grand Rapids, Michigan. Baptists for Life believes in the sacredness of human life at every stage of biological development and in its value throughout the life continuum. It exists to provide alternatives to abortion through the over 2,000 church congregations which it represents.

Lutherans for Life

Lutherans for Life (LFL) is a volunteer pan-Lutheran educational organization seeking to restore respect for life at all its stages and legal protection for unborn children, the handicapped, and the medically dependent. Headquartered in St. Paul, Minnesota, LFL is a Minnesota non-profit corporation with federations in 10 states and over 200 chapters throughout the country.

WELS Lutherans for Life

WELS Lutherans for Life is a para-synod organization in fellowship with the 440,000 member Wisconsin Evangelical Lutheran Synod (WELS). WELS resolved at its 1979 synod convention that "the Holy Scriptures clearly teach that the living yet unborn are persons in the sight of God. . . and that we continue to urge our membership to make God's will in this matter known." WELS Lutherans for Life is that specialized ministry which seeks to make known God's will of life and to provide assistance to others in all life issues.

Moravians for Life

Moravians for Life, also known as MOR'LIFE, is an association of individual members of the North American Moravian Church who are committed to pro-life education and advocacy.

United Church of Christ Friends for Life

United Church of Christ Friends for Life is a duly constituted special interest group within the United Church of Christ. It upholds the sanctity of human life from conception to natural death and speaks to this issue at every opportunity within the denomination. It produces a quarterly newsletter and is in the process of establishing chapters throughout the denomination.

Task Force of United Methodists on Abortion and Sexuality

The Task Force of United Methodists on Abortion and Sexuality is a national network of over 400 United Methodist pastors, theologians, and organizations begun in 1987 to minister to the problems of abortion in society. The view that life does not begin until live birth does not represent the position of a large segment of the United Methodist Church. According to our Discipline, only our General Conference, not our agencies, speaks for the Church. In 1988, General Conference stated in paragraph 71, section G of our Social Principles that "We recognize tragic conflicts of life with life may justify abortion and in such cases support the legal option of abortion under proper medical procedures. We cannot affirm abortion as an acceptable means of birth control and we unconditionally reject it as a means of gender selection." That abortion involves human life before birth is signified by the phrase "conflicts of *life* with *life*" (emphasis added). That abortion should be restricted to minimize indiscriminate practice is signified by saying that "we cannot affirm abortion as an acceptable means of birth control and we unconditionally reject it as a means of gender selection."

Christian Action Council

The Christian Action Council (CAC), founded in 1975 as a Protestant evangelical pro-life organization, is incorporated in the District of Columbia. Since its founding, the CAC has established 400 crisis pregnancy centers around the country. These crisis

pregnancy centers serviced more than 150,000 women in 1987, providing them with support, encouragement, and necessary services to enable them to carry their babies to term. The CAC also counsels and supports women who suffer from the aftermath of abortion. CAC has 120 local CAC affiliate chapters that are activist-oriented and involved politically in promoting pro-life legislation and seeking a reversal of *Roe v. Wade*.

The parties to the present case have consented to the filing of this brief; letters granting consent are being submitted with this brief.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

No. 88-790

BERNARD J. TURNOCK, M.D., M.P.H., et al., – – – – – – – – – – – – – – – – Appellants,

versus

RICHARD M. RAGSDALE, M.D., et al., – – – Appellees.

SUMMARY OF ARGUMENT

This case presents a challenge to various Illinois statutes and regulations alleged to violate the principles set forth in *Roe v Wade*, 410 U.S. 113 (1973), and its progeny. The standard of review governing judicial scrutiny of the challenged requirements depends upon the validity of the *Roe* decision.

In *Roe v. Wade*, this Court erroneously held that unborn children are not "persons" with rights under the fourteenth amendment to the United States Constitution, and that the fourteenth amendment includes a right to abortion. This Court should now repudiate the exclusion of unborn children from constitutional protection, and overrule *Roe v. Wade*.

The fourteenth amendment secures protection for the minimum human rights a state must respect: the rights to life, liberty, and property. This amendment would be of little value, however, if those invoking its guarantees had to bear the burden of proving their entitlement to protection under the amendment. Thus the Court must presume that the amendment applies to all living human beings. Those who assert that a particular class of individuals is outside the scope of the amendment must bear the burden of justifying such an exclusion.

No valid basis exists for excluding human beings conceived but not yet born from the protection afforded "persons" under the fourteenth amendment.

The *Roe* Court offered no defensible justification for such an exception. The alleged absence of precedents for the personhood of unborn children is not only incorrect, but also irrelevant in view of the similar dearth of such precedents for any other class of humans. The postnatal applicability of some provisions of the Constitution referring to "persons" does not imply that those excluded, e.g., from eligibility for Congress or for citizenship, are not persons; moreover, the assertedly ambiguous scope of other constitutional provisions referring to persons provides no basis for anything but circular arguments as to their scope. The alleged inconsistency of exceptions in state anti-abortion laws with the personhood of unborn children merely identifies possible constitutional defects in those laws; such defects do not justify the categorical exclusion, from all constitutional protection, of the class suffering discrimination. The supposed laxity of state abortion legislation in much of the nineteenth century is historically misleading because it ignores the fact that stringent anti-abortion legislation, largely representing a response to the scientific discovery of the humanity of unborn children from the moment of fertilization, preceded and accompanied passage of the fourteenth amendment. Furthermore, even prior to this legislation, abortion was illegal at common law and, until after the technical developments of the late eighteenth century, practically unavailable and virtually suicidal.

Contrary to *Roe*, history, science, logic, law, and justice all weigh in favor of including unborn children within the protection of the fourteenth amendment. The framers of that amendment clearly drew no distinction between "persons" and biological "human beings." Science demonstrates that each individual member of the human race begins life at the moment of fertilization. Logic supports no essential distinction between human beings on the basis of their dwelling inside or outside the maternal womb, or on the basis of their status as "viable" or "nonviable" individuals. Legal consistency supports the rejection of distinctions, in matters of basic rights, between born and unborn children, as well as between "viable" and "nonviable" unborn children. Finally, the intrinsic sanctity of every human life compels

the rejection of any arbitrary exclusion of unborn children from entitlement to the most basic of human rights.

This Court should overrule *Roe v. Wade*. Any challenge to the Illinois laws predicated upon a supposed right to abortion, as in the present appeal, must accordingly fail.

A challenge to the Illinois laws might rest on the basis that these laws insufficiently respect the personhood of the unborn. The appellees have not raised or indicated any wish to raise such constitutional objections; nor would these parties likely have standing to do so. The attorney general, however, who is an appellant in this case, is a proper party to vindicate the rights of unborn children. This Court should therefore uphold the personhood of children conceived but not yet born, and set this case for further briefing and reargument on the question of the proper disposition of this appeal.

ARGUMENT

The decision of the Supreme Court in *Roe v. Wade*, 410 U.S. 113 (1973), rests upon two central holdings: first, that the due process clause of the fourteenth amendment to the United States Constitution provides for a right to abortion; and second, that unborn children are not "persons" possessing a right to life and equal protection of law under the fourteenth amendment.

Analysis and resolution of the present case depends upon the standard of review governing laws which apply to human abortion. Hence, determination of this case hinges upon the status of the *Roe* decision. This brief demonstrates the invalidity of *Roe* by addressing *Roe*'s failure to recognize the personhood, under the fourteenth amendment, of human beings conceived but not yet born.

I. THE BURDEN OF PROOF RESTS UPON THOSE WHO WOULD EXCLUDE UNBORN CHILDREN FROM THE MEANING OF THE TERM "PERSON" UNDER THE FOURTEENTH AMENDMENT.

The fourteenth amendment to the Constitution of the United States provides that "[n]o State shall . . . deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV, §1. This amendment secures protection for the

basic, minimum human rights any state must respect. It is imperative that categories of human beings not be read out of the terms of this amendment without the clearest demonstration of justification for such exceptions.

The Constitution is not a legislative code designed to specify its application in every conceivable situation. "We do not expect to find in a constitution minute details. It is necessarily brief and comprehensive. It prescribes outlines, leaving the filling up to be deduced from the outlines." *Legal Tender Cases*, 79 U.S. (12 Wall.) 457, 532 (1870). Thus, the vitality of constitutional principles depends upon their being presumed to apply. "A close and literal construction deprives them of half their efficacy, and leads to gradual depreciation of the right, as if it consisted more in sound than in substance." *Boyd v. United States*, 116 U.S. 616, 635 (1886).

If there were ever a term whose scope must be presumed to be broad, it is the term "person." For whoever is not a person lacks not only the privileges of citizenship, but even the barest minimum of human rights. A person need not have every right -- prisoners, minors, and aliens, for example, do not possess the full panoply of rights and privileges afforded under the Constitution -- but a non-person has *no* rights whatsoever. A non-person is no better off than property, entirely subject to the whim of the owner and whatever permissible regulation the state may deign to impose.

The constitutional protection for "persons" simply cannot function if each individual or class of human beings must prove inclusion in the roll of "persons." Does the term "person" include mentally disabled individuals? There is not likely much, if any, explicit support for that particular proposition in the text, history, or early application of the fourteenth amendment. Yet these are certainly persons. Does "person" include citizens of hostile nations? Children under the age of eighteen? Convicted misdemeanants or felons? Comatose individuals? Each of these classes of human beings lacks either the legal or physical ability to exercise certain rights, yet each is unquestionably a class of persons. This is so, not because members of each class can *prove* their inclusion under the fourteenth amendment, but because they are *presumed* included absent decisive contrary proof. "They are humans, live, and have their being." *Levy v. Louisiana*, 391 U.S. 68, 70 (1968) (discussing

illegitimate children). Therefore, "[t]hey are clearly 'persons' within the meaning of the Equal Protection Clause of the Fourteenth Amendment." *Id.*

Human offspring conceived but not yet born are likewise "humans, live, and have their being." They do not need to overcome any additional hurdles in order to establish their right to presumptive inclusion within the term "person" as used in the fourteenth amendment. If unborn children are not persons, it must be because some further evidence authoritatively rebuts this presumption. No such evidence, however, exists.

II. THERE IS NO JUSTIFICATION FOR EXCLUDING FROM THE TERM "PERSON" THE CLASS OF HUMAN BEINGS CONCEIVED BUT NOT YET BORN.

In *Roe v. Wade*, 410 U.S. 113, 158 (1973), the Court read into the term "person" in the fourteenth amendment an exception for unborn children. There is no valid justification for the creation of such an exception.

A. *Roe v. Wade* Gave No Valid Basis for Creating an Exception for Unborn Children.

The *Roe* Court made several arguments to support its conclusion that the word "person" does not include the unborn. None of these arguments withstands analysis.

1. Alleged absence of precedent

First, the Court observed that "no case could be cited that holds that a fetus is a person within the meaning of the Fourteenth Amendment." 410 U.S. at 157.

This observation is incorrect as a matter of fact. In *Steinberg v. Brown*, 321 F. Supp. 741 (N.D. Ohio 1970) (three-judge court), the court rejected a challenge to Ohio's abortion laws, holding that the implied right to privacy

> must inevitably fall in conflict with the express provisions of the Fifth and Fourteenth Amendments that no *person* shall be deprived of life without due process of law. The difference between this case and *Griswold* [overturning a

> ban on the use of contraceptives] is clearly apparent, for *here there is an embryo or fetus* incapable of protecting itself.

Id. at 745-46 (emphasis added). As the court in *Steinberg* explained, "a new life comes into being with the union of human egg and sperm cells," *id.* at 746, and "[o]nce human life has commenced, the constitutional protections found in the Fifth and Fourteenth Amendments impose upon the state a duty of safeguarding it," *id.* at 746-47.

Moreover, as a legal matter, an absence or dearth of case support for unborn personhood is irrelevant. There may well not be any cases, for example, holding newborn infants to be persons. This obviously does not mean, however, that such children are beyond the scope of the fourteenth amendment. As discussed above, such a cramped construction of the text would largely negate the effect of the amendment.

2. Postnatal application of other constitutional provisions

Second, the Court noted that the use of the word person in "nearly all" other parts of the Constitution "is such that it has application only postnatally. None [of these uses] indicates, with any assurance, that it has any possible prenatal application." 410 U.S. at 157 (footnote omitted). But this simply begs the question. Those provisions that *cannot* apply prenatally explicitly limit the class of human beings to which they apply, *e.g.*, U.S. Const. art. I, § 2, cl. 2 (person must be at least age twenty-five to be a Representative); *id.* art. I, § 3, cl. 3 (person must be at least age thirty to be a Senator); *id.* amend. XIV, § 1 (person who is born, if born in the United States, is a citizen). Such exclusions obviously do not imply that those excluded (e.g., with respect to Representatives, those under age twenty-five) are not persons. Moreover, those provisions that can apply to unborn children,[1] *e.g.*, *id.* art. I, § 9, cl. 1 (tax on importation of "persons"); *id.* amend. IV (security of the person against unreasonable searches and seizures); *id.* amend. V (due process requirement for deprivation of life), contain no exclusion for any particular class of children, born or unborn. Again, the burden is on those who would create an exception, not those who claim inclusion.

[1] It bears mention that the holding of an office need not, in theory, be limited to competent adults. History, for example, has seen numerous infants wear the royal crown. Furthermore, unborn children have been explicitly recognized as capable of serving as the executor of an estate. H. Storer, *Criminal Abortion in America* 92 (1860) ("an infant in utero . . . at every stage of [gestation], no matter how early, . . . may be appointed executor . . . "). *Accord Thellusson v. Woodford*, 31 Eng. Rep. 117, 163 (Ch. 1798).

3. Apparent inconsistency of state anti-abortion laws with personhood of unborn children

Third, the Court pointed to allegedly fatal inconsistencies in the abortion laws of Texas and other states.

> [I]f the fetus is a person who is not to be deprived of life without due process of law, . . . does not the Texas exception [for abortion necessary to save the life of the mother] appear to be out of line with the Amendment's command? . . .
>
> . . . If the fetus is a person, why is the woman not a principal or an accomplice [to an unlawful abortion]? . . . If the fetus is a person, may the penalties be different [for abortion and first degree murder]?

Roe, 410 U.S. at 157 n.54.

Here the *Roe* Court confused two distinct issues: the constitutionality of the Texas abortion laws, and the constitutional personhood of unborn children.

A state, of course, may not exclude from the general protection of the criminal law a particular class of innocent persons.[2] *See infra* p. 23. This fundamental obligation does not disappear, however,

[2] Whether an exception for the life of the mother would entail a denial of equal protection to unborn persons would depend upon the scope of that exception. There is a grave moral and legal difference between, on the one hand, allowing a physician to remove an ectopic pregnancy or cancerous uterus from a pregnant woman, with the death of her unborn child occurring as an unintended effect of that necessary operation, and, on the other hand, giving permission for the direct, intentional killing of the unborn child whenever such is claimed to be necessary to save the mother's life.

The total exemption of the pregnant woman herself from the scope of criminal prohibitions against abortion would, like total parental immunity from prosecution for serious child abuse, be unconstitutional. *But cf. Michael M. v. Superior Court*, 450 U.S. 464 (1981) (sustaining, against equal protection challenge, statutory rape law that only applied to male offenders).

(cont'd on next page)

simply because a state fails to comply with it. In *Brown v. Board of Education*, 347 U.S. 483 (1954) (*Brown I*), for example, it would have been outrageous to suggest that the long history and widespread practice of segregated public education meant that black people were not persons. On the contrary, this segregation represented a constitutional violation.

Similarly, the denial of equal statutory treatment to unborn children does not support a categorical denial of constitutional protection to such children. As the Court emphasized in *Brown v. Board of Education*, 349 U.S. 294, 300 (1955) (*Brown II*), "the vitality of these constitutional principles cannot be allowed to yield simply because of disagreement with them." If the state in fact is denying due process or equal protection to a class of humans, the remedy is to declare the discrimination unconstitutional, not to deny the personhood of the victimized class. To hold otherwise would be to deny the possibility of unconstitutional action by states, and to turn civil rights litigation upside down.

4. Alleged laxity of nineteenth century abortion laws

Fourth, the Court cited its "observation" that "throughout the major portion of the 19th century prevailing legal abortion practices were far freer" than in 1973, *Roe*, 410 U.S. at 158, presumably as evidence that the framers and those who ratified the fourteenth amendment did not regard unborn children as human persons.

On this point the *Roe* opinion refutes itself. The fourteenth amendment was adopted in 1868, precisely the time when the scientific discovery of the humanity of the unborn had become widely known, and precisely the time when this discovery had prompted vig-

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Prosecutorial discretion, of course, is fully capable of handling situations in which the mother is more accurately considered a victim instead of an offender.

The primary effect of holding the unborn child to be a person would be that the child could no longer be regarded as beyond the equal protection of the criminal law. In other words, if all of the elements of a statute defining an offense against a person were satisfied, the statute could not be held inapplicable simply because the victim was not yet born.

The state may properly create a separate and additional offense of abortion which could apply without proof of pregnancy or causation of fetal death.

orous opposition to abortion by means of numerous statutory bans. *See* 410 U.S. at 129 (observing that abortion laws in effect in 1973 "derive from statutory changes effected, for the most part, in the latter half of the 19th century"); *id.* at 141 (noting the "anti-abortion mood prevalent in this country in the late 19th century"); *id.* at 141-42 (noting that the concern of the medical profession for prenatal human life destroyed by abortion "may have played a significant role in the enactment of stringent criminal abortion legislation during that period"); *see also id.* at 174-77 (Rehnquist, J., dissenting) (noting the multiplicity of state and territorial anti-abortion laws at the time of the adoption of the fourteenth amendment).

Furthermore, the assumption by the *Roe* Court that abortion was freely and legally available, even in the early part of the nineteenth century, simply ignores reality. As Professor Joseph W. Dellapenna has demonstrated, the primitive state of medical technology meant that, prior to the late eighteenth century, abortion techniques were either ineffective or so dangerous as to be practically suicidal. Dellapenna, *The History of Abortion: Technology, Morality, and Law*, 40 U. Pitt. L. Rev. 359, 371-76 (1979). Thus, while abortion was indeed unlawful at common law, prosecutions were infrequent because they were unnecessary. Dellapenna, "Abortion and the Law," in *Abortion and the Constitution* 137, 146 (D. Horan, E. Grant & P. Cunningham eds. 1987).

> During this period, techniques to induce abortions were either magical, and hence punishable as witchcraft (whether they were successful or not), or extremely crude invasions of the woman's body, likely to be fatal to the woman as well as to the fetus. In the few cases where an abortionist was punished, it was for killing the mother. In fact, there is no evidence of voluntary abortion during this time. Abortions, if they occurred, seem to have resulted from assaults upon women rather than by their choice. Even then, abortion prosecutions were hampered by ignorance of medical knowledge about the gestation process. The net result of these circumstances was that abortion was rare and the law did not have to deal with it because hanging the abortionist for killing the mother was sufficient punishment for the few cases that did arise.

Id. at 145 (footnotes omitted). The disposal of "unwanted" children was effectuated instead by infanticide. *Id.* (citing numerous authorities). When new abortion techniques finally became available in the late eighteenth century, the result was the initiation of anti-abortion legislation. *Id.* at 146. This legislative movement subsequently expanded in response to embryological discoveries that identified fertilization as the beginning of human life. *Id.* at 147.

B. No Other Basis Exists For Creating an Exception for Unborn Children.

Roe failed to give any justification for reading an exception for unborn children into the scope of the term "person" as used in the fourteenth amendment. Nor does any valid justification appear from other sources. On the contrary, history, science, logic, law, and justice all militate against the imposition of any such arbitrary limitation on personhood as birth or viability.

1. The framers of the fourteenth amendment did not distinguish between "human beings" and "persons."

Roe v. Wade distinguished between human beings and persons, holding that unborn children were not persons even if they were human beings. 410 U.S. at 159 ("We need not resolve the difficult question of when life begins"). Such a distinction, however, was foreign to the men who proposed and adopted the fourteenth amendment.

If one thing is overwhelmingly clear from the record of the debates leading up to and surrounding the thirteenth and fourteenth amendments and the post-war civil rights legislation, it is that the legislators considered personhood and biological humanity to be interchangeable terms.

Thus Representative Thaddeus Stevens, on the day the thirteenth amendment was declared ratified, proclaimed:

> This is man's Government; the Government of all men alike; not that all men will have equal power and sway within it. Accidental circumstances, natural and acquired endowment and ability, will vary their fortunes. But equal rights to all the privileges of Government is *innate in every immortal being, no matter what the shape or color of the tabernacle which it inhabits.*

Cong. Globe, 39th Cong., 1st Sess. 74 (1865) (emphasis added).

Likewise Representative John A. Bingham, author of section one of the fourteenth amendment, declared in reference to the fifth amendment the principle he viewed as fundamental:

> [T]he Constitution of the United States . . . declared that "no person shall be deprived of life, liberty, or property without due process of law." By that great law of ours it is not inquired whether a man is "free" by the laws of England; it is only to be inquired *is he a man*, and therefore free by the law of that creative energy which breathed into his nostrils the breath of life, and he became a living soul, endowed with the rights of life and liberty. . . . Before that great law *the only question to be asked of a creature claiming its protection is this: Is he a man?* Every man is entitled to the protection of American law, because its divine spirit of equality declares that all men are created equal.

Cong. Globe, 40th Cong., 1st Sess. 542 (1867) (emphasis added).

Representative James S. Brown, similarly, denied the notion that personhood required something more than human life.

> [D]oes the term "person" carry with it anything further than a simple allusion to the existence of the individual? It certainly cannot be strained into any recognition of slavery, since the very recognition of personality excludes [an institution which] does not regard its victims as persons but as chattels.

Cong. Globe, 38th Cong., 1st Sess. 1753 (1864).

Indeed, examples are legion to demonstrate the basic assumption of the framers and their contemporaries that "in the eyes of the Constitution, every *human being* within its sphere . . . from the President to the slave, is a *person*." Cong. Globe, 37th Cong., 2d Sess. 1449 (1862) (Sen. Sumner) (first emphasis added). [3]

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[3] *E.g.*, Cong. Globe, 39th Cong., 1st Sess. 77 (1866) (Sen. Trumbull) ("any legislation or any public sentiment which deprives any human being in the land of those great rights of liberty will be in defiance of the constitution"); *id.* at 322-23 (1866) (Sen. Trumbull) ("great object of

There is, therefore, no warrant for the conclusion that a class of human beings might be excluded from the persons protected under the fourteenth amendment. As forcefully stated by Representative Joshua R. Giddings,

> Our fathers, recognizing God as the author of human life, proclaimed it a "self-evident" truth that every human being holds from the Creator an inalienable right to live . . . .
>
> . . . If this right be denied, no other can be acknowledged. If there be exceptions to this central, this universal proposition, that *all* men, without respect to complexion or condition, hold from the Creator the right to live, who shall determine what portion of the community shall be slain? And who may perpetrate the murders?

Cong. Globe, 35th Cong., 1st Sess. App. 65-66 (1858) (emphasis in original).

2. Science rejects the exclusion of unborn children from the class of human beings.

Science does not purport to identify the value society should place upon human life. Science does indisputably show, however, that each individual human organism begins life at the moment of fertilization. Thus science offers no valid basis for excluding prenatal human life from the category of "persons" protected under the fourteenth amendment.

> However one answers the metaphysical or theological question whether the fetus is a "human being" or the legal question whether it is a "person" as that term is used in the Constitution, one must at least recognize, first, that the

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securing to every human being within the jurisdiction of the Republic equal rights before the law"); *id.* at 1159 (1866) (Rep. Windom) (rights to life, liberty, and pursuit of happiness are "rights of human nature," and the most basic "right of human nature [is] the right to exist"); *id.* at 1151 (1866) (Rep. Thayer) ("relief of human nature" secured in thirteenth amendment); 3 Cong. Rec. 1794 (1875) (Sen. Thurman) (may not deny equal protection to "any person" in the jurisdiction, "be he sane or be he insane, *be he old or be he young*, be he innocent or be he criminal, be he learned or be he ignorant") (emphasis added).

> fetus is an entity that bears in its cells all the genetic information that characterizes a member of the species homo sapiens and distinguishes an individual member of that species from all others, and second, that there is no nonarbitrary line separating a fetus from a child or, indeed, an adult human being.

Thornburgh v. American College of Obstets. & Gynecs., 476 U.S. 747, 792 (1986) (White, J., joined by Rehnquist, J., dissenting).

This principle of continuous development is not unique to human beings.

> In biology and in medicine, it is an accepted fact that the life of *any* individual organism reproducing by sexual reproduction begins at conception, or fertilization -- the time when the egg cell from the female and sperm cell from the male join to form a single new cell, the zygote. The zygote is the starting cell of the new organism.
>
> . . . It is important to also remember . . . that like begets like. In other words, the zygote is always a member of the biological species of its parents from the time of fertilization throughout all of its life, before as well as after birth. No study or experiment has ever refuted these scientific facts, and no competent scientist denies them.

The Human Life Bill: Hearings on S.158 Before the Subcomm. on Separation of Powers of the Senate Comm. on the Judiciary, 97th Cong., 1st Sess. 14, 16 (1982) (testimony of Dr. Micheline Mathews-Roth, principal research associate, Dept. of Medicine, Harvard Medical School) (emphasis added). The conclusion in the case of human life rests, therefore, not only upon human embryological research, but upon the findings of a broad area of biological study.

> So, therefore, it is scientifically correct to say that an individual human life begins at conception, when egg and sperm join to form the zygote, and that this developing human always is a member of our species in all stages of its life.

Id. at 17. *Accord* W. Hamilton & H. Mossman, *Human Embryology* 14 (4th ed. 1972) ("the fusion of two germ cells . . . one, the

spermatozoan from the male parent; the other, the ovum from the female parent . . . is the formation of the first cell of the new individual, the zygote"); L. Arey, *Developmental Anatomy* 55 (7th ed. 1974) (union "of a male and female sex cell . . . definitely marks the beginning of a new individual"); K. Moore, *The Developing Human: Clinically Oriented Embryology* 1 (2d ed. 1977) (a zygote "results from fertilization of an oocyte by a sperm and is the beginning of human life").[4]

Science cannot identify a spiritual soul or assign a moral value to a given creature. Science does identify individual members of a particular species, such as homo sapiens. Unborn children are unquestionably individual members of this species, and thus the conclusions of science utterly reject the arbitrary exclusion of prenatal humans from the term "person."

3. Logic militates against the creation of an exception for unborn children in the term "person."

According to *Roe v. Wade*, unborn children are non-persons, and abortion of such children is a constitutional right. But it is plainly absurd to draw so tenuous a border as birth (or, for that matter, viability) between what is a constitutional liberty and what is homicide.

First of all, the act of abortion itself cannot sensibly be what distinguishes between persons and non-persons. Presumably no member of this Court would deny that "a newborn infant, whether the product of a normal birth or an abortion," *Planned Parenthood Ass'n of Kansas City,* Mo. v. Ashcroft, 462 U.S. 476, 503 n.10 (1983)

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[4] *See also Corkey v. Edwards*, 322 F. Supp. 1248 (W.D.N.C. 1971), *vacated*, 410 U.S. 950 (1973):

> During fertilization, sperm and egg pool their nuclei and chromosomes. Biologically, a living organism belonging to the species homo sapiens is created out of this organization. Genetically, the adult man was from such a beginning all that he essentially has become in every cell and human attribute.

322 F. Supp. at 1252 (citations omitted). *Accord Rosen v. Louisiana State Bd. of Medical Examiners,* 318 F. Supp. 1217, 1223 (E.D. La. 1970), *vacated*, 412 U.S. 902 (1973); *Steinberg v. Brown*, 321 F. Supp. 741, 746-47 (N.D. Ohio 1970) (three-judge court); *Presley v. Newport Hosp.*, 117 R.I. 177, ___ , 365 A.2d 748, 751 (1976).

(Blackmun, J., joined by Brennan, Marshall, and Stevens, JJ., dissenting), is a person under the fourteenth amendment.

The point of detachment from the mother -- whether by normal birth, induced delivery, or abortion -- likewise fails as a logical point for creating an exception to personhood. For a considerable period prior to birth, the unborn child is viable, and thus capable of surviving premature delivery. The child of seven or eight months' gestation who still resides in the maternal womb is essentially indistinguishable from the child of identical age who has been born prematurely.

The fourteenth amendment does distinguish between born and unborn children of the same age for purposes of citizenship. *See* U.S. Const. amend. XIV, § 1 ("persons born . . . in the United States . . . are citizens"). But citizenship is a political classification the boundaries of which are necessarily arbitrary.

Personhood, in contrast, entitles an individual to the basic, minimal protections accorded to humanity. Whether the mother in labor while traveling interstate gives birth in Texas today or Mexico tomorrow is a question with political ramifications for the child; such incidental details, however, cannot reasonably determine whether the child may be slain. "No governmental power exists to say that a viable fetus should not have every protection required to preserve its life." *Thornburgh*, 476 U.S. at 784 (Burger, C.J., dissenting). As Senator Arthur S. Boreman explained in regard to the then recently enacted protections of the fourteenth amendment:

> This . . . is not confined to citizens of the United States, but it includes every person that is found within these States, and guaranties to all life, liberty, and property, and equal protection of the laws. . . . It is not restricted to guarantying the right of a "citizen" . . . but it extends to every "person," whether he has come from another State or not, to *every person residing anywhere, everywhere,* within the United States. So that while, before this amendment, if there was any question whether there were any class of persons in this country over whom the protection of the Constitution of the United States was not extended, there cannot now be any longer any question on that subject.

Cong. Globe, 42nd Cong., 1st Sess. App. 229 (1871) (emphasis added).

The total meaninglessness of birth as a criterion for personhood is more apparent today than ever, when induced, "scheduled" deliveries are commonplace, when babies are removed from the womb for surgery and then replaced within their mothers, and when irremediably harmed mothers are sustained on life support systems solely to await the delivery of the uninjured child within the womb.[5] Birth changes *where* the person is, not *what* the person is.

Nor does the concept of viability supply a logical alternative to birth as a boundary for excluding some unborn children from personhood.

> If we profess allegiance to reason, it would be seditious to adopt so arbitrary and uncertain a concept as viability as a dividing line between those persons who shall enjoy the protection of our remedial laws and those who shall become, for most intents and purposes, nonentities. It seems that if live birth is to be characterized, as it so frequently has been, as an arbitrary line of demarcation, then viability, when enlisted to serve that same purpose, is a veritable *non sequitur*.

Presley v. Newport Hosp., 117 R.I. 177, ___, 365 A.2d 748, 754 (1976).

Members of this Court have already strongly criticized reliance upon the concept of viability for drawing constitutional lines. *Webster v. Reproductive Health Services*, 109 S. Ct. 3040, 3057 (1989) (plurality opinion). *See, e.g., City of Akron v. Akron Center for Reprod. Health, Inc.*, 462 U.S. 416, 456-58 (1983) (O'Connor, J., joined by White and Rehnquist JJ., dissenting) (point of viability is unstable because tied to contemporaneous state of medical technol-

[5] Already *in vitro* fertilization and embryonic transfer have demonstrated beyond all doubt the fundamental biological independence of the newly conceived child from any particular woman, genetic mother or not, and the capacity of an unborn child to live outside of the womb altogether, if only for the initial stages of development. It is now clear, in other words, that intrauterine gestation is not even the first stage of life, but is merely an intermediate stage subject to technical manipulation regarding both its duration and the identity of the woman who bears the child.

ogy, and is therefore unsuitable as a basis for judicial decision making). Justice White, in his dissent in *Thornburgh*, elaborated upon this point with regard to the state interest in protecting human life:

> The government interest at issue is in protecting those who will be citizens if their lives are not ended in the womb. The substantiality of this interest is in no way dependent on the probability that the fetus may be capable of surviving outside the womb at any given point in its development, as the possibility of fetal survival is contingent on the state of medical practice and technology, factors that are in essence morally and constitutionally irrelevant. The State's interest is in the fetus as an entity in itself, and the character of this entity does not change at the point of viability under conventional medical wisdom. Accordingly, the State's interest, if compelling after viability, is equally compelling before viability.

476 U.S. at 795 (White, J., joined by Rehnquist, J., dissenting) (footnote omitted). The same rationale applies to constitutional personhood, i.e., the claim to minimal protection of basic human rights. One's capacity for survival is "constitutionally irrelevant" because "the character of the entity does not change at the point of viability."

The very notion of viability as a criterion for denying legal protection is gravely flawed. Viability is not a transcendent concept -- it refers to conditional circumstances. The Arctic explorer is viable *if* sufficiently clothed. The serious diabetic is viable *if* properly treated. The newborn, full-term infant is viable *if* fed and nurtured. And the unborn child is viable *if* not prematurely expelled from the necessary environment, be it a petri dish or a womb. To deny protection on the basis of one's need for protection is no more sensible than to deny those who cannot swim the right to stay on board a ship. *Roe* stripped protection from precisely those who most need the minimum safeguards of the fourteenth amendment. This is topsy-turvy jurisprudence.

4. Legal consistency would not be served by the exclusion of unborn children from the protection of the fourteenth amendment.

The integrity of the law is not served, but rather is harmed, by the arbitrary exclusion of unborn children from constitutional protection. The history of legal developments of the past century and a half regarding prenatal human life has been a history of increasing recognition and protection of unborn children. The creation of an exception to the fourteenth amendment which would deny protection to such children represents a reversion to outmoded and unworkable legal fictions, and leads to disrespect for the law.

The ordinary legal guardians of the civil rights to life, liberty, and property are the criminal law and the law of torts. In both of these areas of law, courts and litigants have struggled with, and to a certain extent overcome, the absurdity and injustice of arbitrary distinctions between born and unborn children, and between viable and nonviable unborn children.

The common law is considerably older than contemporary knowledge of prenatal human development. Ignorance of fertilization and the nature of the human embryo consequently left its marks on the common law. In particular, the considerable problems of proof facing those alleging the perpetration of wrongs against unborn children led to the recognition of various arbitrary rules. These rules, for want of better guides, tied civil and criminal liability to observable phenomena such as quickening (the detection of the child moving in the womb) and live birth.

The criminal law has found it difficult to "outgrow" these arbitrary rules, presumably because of a combination of stare decisis, concern for advance notice to defendants of the criminality of particular conduct, and the rule of strict construction in favor of the defendant. *E.g., Keeler v. Superior Court,* 2 Cal. 3d 619, 470 P.2d 617, 87 Cal. Rptr. 481 (1970) (en banc). As a result, the general rule today remains that the homicide of an unborn child cannot be established without proof that the mortally wounded infant survived, even if only momentarily, outside the womb. *See* Annotation, *Homicide Based on Killing of Unborn Child,* 40 A.L.R.3d 444 (1971). States have responded to this archaic requirement, however, by amending their criminal codes and specifying that the destruction

of an unborn child is a crime.[6]

The law of torts has demonstrated a greater ability to "keep pace with the sciences," *Bonbrest v. Kotz*, 65 F. Supp. 138, 143 (D.D.C. 1946) (allowing action for prenatal injuries), and to adjust its rules of liability in the face of increased scientific knowledge. Thus, for example, the courts have overwhelmingly recognized the right of a live child to recover for prenatal injuries, even if inflicted prior to viability. Annotation, *Liability for Prenatal Injuries*, 40 A.L.R.3d 1222 (1971). Likewise, the courts universally allow recovery for the wrongful death of a child born alive whose injuries were inflicted before birth. Annotation, *Right to Maintain Action or to Recover Damages for Death of Unborn Child*, 84 A.L.R.3d 411 (1978). Similarly, after a protracted struggle over the issue, the courts of a clear majority of jurisdictions — thirty-four states including the District of Columbia, with eleven opposed, and five undetermined — now allow recovery for the wrongful death of a viable unborn child who dies while still in the womb. *Id.*[7] And while few courts have addressed the issue, already one state supreme court has convincingly argued that wrongful death liability cannot sensibly be limited to wrongs inflicted upon viable unborn children. *Presley v. Newport Hosp.*, 117 R.I. 177, 365 A.2d 748 (1976).

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[6]*E.g.*, Cal. Penal Code § 187 (West 1988) (murder); Ill. Ann. Stat. ch. 38, paras. 9-1.2, 9-2.1, 9-3.2 (Smith-Hurd Supp. 1989) (homicide and manslaughter of unborn child); La. Rev. Stat. Ann. § 14:2(7) (West 1986) (defining "person" in criminal code as including "a human being from the moment of fertilization and implantation"); Minn. Stat. Ann. §§ 609.2661-609.2665, 609.268 (West 1987) (murder, manslaughter, and felony death of unborn child); N.D. Cent. Code § 12.1-17.1-02 to 12.1-17.1-04 (Supp. 1989) (murder, manslaughter, and negligent homicide of unborn child).

One of the curious consequences of the difficulties in proving destruction of unborn children was that the lives of such children could better be protected by laws prohibiting abortion without proof of pregnancy, destruction of the unborn child, or intent to destroy such child. The American Medical Association incorporated precisely these features in its model anti-abortion statutes in the nineteenth century. *See* 13 Transactions of the American Medical Association 41-42 (1860); H. Storer, *Criminal Abortion in America* 94, 97-100 (1860).

[7]One additional state, Tennessee, has legislated this result. *See* Tenn. Code Ann. § 20-5-106 (1980) (legislatively overruling *Hamby v. McDaniel*, 559 S.W.2d 774 (Tenn. 1977)). Thus, thirty-five jurisdictions now allow recovery, while ten deny recovery.

Roe's imposition of birth and viability requirements (as predicates for personhood and a compelling state interest in protecting prenatal life, respectively) therefore represented a major setback in the law. *Roe* embraced the very same distinctions that the law of torts (and, to a lesser extent, crime) was in the process of finally and completely repudiating.

The consequences in terms of respect for the law are all too obvious. The jealous ex-husband who forcibly aborts his pregnant ex-wife's child may be convicted of homicide, but the professional abortionist cannot be. A woman who is hit by a car and miscarries on the way to an abortion business may sue for the loss of the child she planned to destroy. A disabled child may recover large sums to compensate for harm suffered in the womb, but the mother could have had that same child killed because she did not want a handicapped baby.

Such contrasts make a mockery of the law. The malleable and uncertain lines separating viability from nonviability, or prematurity from pregnancy, simply cannot support the difference between constitutional rights and crimes. The shifting sands of consent to abortion cannot support the distinction between homicidal torts and constitutional liberties.

Either the unborn child is a person, or he is not. While the law in theory can consider someone a person for some purposes and not for others, in practice such artificiality results in contempt for a legal system full of technicalities that contradict reality. The integrity of the legal system calls for inclusion, not exclusion, of the class of unborn children within the term "person" in the fourteenth amendment.

5. Justice demands the inclusion of unborn children within the term "person."

Finally, considerations of justice call for the renunciation of the arbitrary denial of equal protection to children who happen to reside within their mothers' wombs.

Not everyone has *every* right. But no one except a person has *any* rights. Thus *Roe v. Wade* asked the wrong question when it queried whether unborn children were "recognized in the law as persons in the whole sense," 410 U.S. at 162. The issue is not whether

children conceived but not yet born should receive the full range of the rights of citizenship, such as the right to vote, but whether they may lay claim to the barest minimum of human rights: "the right to *survive* on a basis of equality with human beings generally," *Rosen v. Louisiana State Bd. of Medical Examiners,* 318 F. Supp. 1217, 1226 (E.D. La. 1970), *vacated*, 412 U.S. 902 (1973) (emphasis added). The law prior to *Roe* had generally accorded that much recognition, and more, to the child in the womb. And in so doing the law recognized a difference in kind between unborn children and tonsils, worms, or trees. This difference is the difference of personhood.

This difference, then, relates to the inherent dignity of man. Personhood is what characterizes the collection of diverse entities that together compose the human race. As Justice Brennan put it in another context,

> At bottom, the battle has been waged on moral grounds. The country has debated whether a society for which the dignity of the individual is the supreme value can, without a fundamental inconsistency, follow the practice of deliberately putting some of its members to death.

Furman v. Georgia, 408 U.S. 238, 296 (1972) (Brennan, J., concurring) (overturning Georgia death penalty). If this observation holds true with regard to the life of a convicted felon, it is much more so for the innocent baby growing in the womb.

The answer to the fundamental moral issue, moreover, is clear: society "must treat its members with respect for their intrinsic worth as human beings," for "if the deliberate extinguishment of human life has any effect at all, it more likely tends to lower our respect for life and brutalize our values." *Id.* at 270, 303 (Brennan, J., concurring).

Justice Harlan, dissenting in *Poe v. Ullman*, 367 U.S. 497 (1961), emphasized the central role of tradition and history in the interpretation of the Constitution. "A decision of this Court which radically departs from it could not long survive, while a decision which builds on what has survived is likely to be sound." *Id.* at 542 (Harlan, J., dissenting).

Roe v. Wade represents precisely such a radical departure from

the history, indeed the founding principles, of this nation. Like *Betts v. Brady*, 316 U.S. 455 (1942), overruled in *Gideon v. Wainwright*, 372 U.S. 335 (1963), *Roe* "made an abrupt break" with what "seems to us to be an obvious truth," *Gideon*, 372 U.S. at 344: "We hold these truths to be self-evident: that all men are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are Life, Liberty, and the pursuit of Happiness." The Declaration of Independence para. 2 (U.S. 1776).

The fourteenth amendment was adopted to secure these rights "not only for the sake of . . . the unfortunate human beings for whose special relief it [was] designed," but "for the purpose as well of giving a new assurance . . . that no man shall ever, in the coming future, as long as the Republic stands . . . be deprived of his life, of his liberty, or his property without due process of law." Cong. Globe, 37th Cong., 2d Sess. 1640 (1862) (Rep. Bingham). As this Court explained in *West Virginia Board of Education v. Barnette*, 319 U.S. 624, 638 (1943), the "very purpose" of a constitutional declaration of rights

> was to withdraw certain subjects from the vicissitudes of political controversy, to place them beyond the reach of majorities and officials and to establish them as legal principles to be applied by the courts. One's right to life . . . and other fundamental rights may not be submitted to a vote; they depend on the outcome of no elections.

Roe v. Wade created an exception to personhood where none existed or could exist. This Court should now correct this fundamental injustice by overruling *Roe v. Wade* and upholding the right to life and equal protection of all human beings, regardless of age, size, health, or condition of dependency.

III. THE PERSONHOOD OF THE UNBORN REQUIRES THE REJECTION OF APPELLEES' ATTACK UPON THE ILLINOIS STATUTES AND REGULATIONS.

The fourteenth amendment personhood of human beings conceived but not yet born dictates the rejection of the appellees' constitutional challenge to the Illinois legislation and regulations at issue here.

Appellees predicate their challenge upon an alleged "fundamental right" to abortion, Motion to Affirm at 17 & n.11 (discussing standard of review). Such a "right," however, is fundamentally inconsistent with the right to life of persons conceived but not yet born. A "right" to abort, where the life of an unborn person is at stake, would make no more sense than "a liberty interest in firing a gun where the case at hand happens to involve its discharge into another person's body," *Michael H. v. Gerald D.*, 109 S. Ct. 2333, 2342 n.4 (1989) (plurality opinion). As this Court acknowledged in *Roe*, "[i]f this suggestion of personhood is established, the [challengers'] case, of course, collapses, for the fetus' right to life would then be guaranteed specifically by the [Fourteenth] Amendment." 410 U.S. at 156-57.

It is true, of course, that the personhood of unborn children imposes a duty upon the state to afford equal protection to humans conceived but not born. *Cf. DeShaney v. Winnebago Dept. of Social Services*, 109 S. Ct. 998, 1004 n.3 (1989) ("The State may not, of course, selectively deny its protective services to certain disfavored minorities without violating the Equal Protection Clause") (citation omitted). As Justice Stevens observed in the *Thornburgh* case, unless there is a "fundamental" difference between unborn and born human offspring, "the permissibility of terminating the life of the fetus could scarcely be left to the will of the state legislatures." 476 U.S. at 779 (footnote omitted). Thus, in view of the general prohibition of homicide, a proper litigant could challenge the constitutionality of laws which did not provide at least the minimum equal protection demanded by the fourteenth amendment: the outlawing of all abortions.

Appellees have not challenged the Illinois laws on this basis. Nor have they indicated any desire to do so. Moreover, it is far from clear that appellees, who are not guardians of unborn children, and whose interests are manifestly opposed to those of such children, have standing to raise objections predicated upon the personhood of the unborn. The Attorney General of Illinois, however, who is an appellant in this case, is a proper party to seek vindication of the rights of unborn persons. This Court should therefore hold that the fourteenth amendment protects unborn children as persons, and set this case for further briefing and reargument on the question of the proper

disposition of this particular appeal.[8]

This Court followed a similar course in the school desegregation cases. In *Brown v. Board of Education,* 347 U.S. 483 (1954) *(Brown I)*, this Court declared that racial segregation in public education violated the fourteenth amendment. The Court then set further proceedings to consider the implications of *Brown I* for the resolution of the particular cases before it. See *Brown v. Board of Educ.*, 349 U.S. 295 (1955) *(Brown II)*. Recognition of the constitutional rights of unborn children would, like the holding in *Brown I*, represent a very significant vindication of fundamental human rights. Thorough review of the ramifications of this holding, as well as the proper means of upholding these rights in the case at bar, would therefore be wise.

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[8] Most of the challenged Illinois provisions, viewed in light of the personhood of the unborn, are clearly constitutional. These laws merely impose general medical regulations wholly consistent with the constitutional rights of unborn persons.

On the other hand, statutes or regulations which authorize any abortions, like certain of the Illinois regulations, Ill. Admin. Code tit. 77, §§ 205.710, 205.740, violate the fourteenth amendment. Any allowance of intentional destruction of unborn persons denies equal protection to such persons. *DeShaney v. Winnebago County Dept. of Social Services,* 109 S. Ct. 998, 1004 n.3 (1989).

Some of the challenged statues and regulations expressly apply to the commission of abortions, but do not explicitly authorize abortions. *E.g.*, Ill. Ann. Stat. ch. 111 1/2, paras. 157-8.3(A) (Smith-Hurd Supp. 1989), and 157-8.6-1 (Smith Hurd 1988); Ill. Admin. Code tit. 77, §§ 205.120(b)(5)(F), 205.520(b)(3), 205.730(a)(2), (3), 205.760. If these laws were to be construed to authorize abortions, they would be unconstitutional. On the other hand, these laws could be construed to apply only to such abortions as are independently authorized under other provisions of law. Under this interpretation, the challenged sections would themselves pose no threat to the constitutional rights of unborn persons. Once laws permitting or authorizing abortions gave way to recognition of the constitutional rights to life and equal protection, laws merely assuming the legality of abortion would become, as applied to abortion, dead letters. Thus, a construction is readily available which saves, from facial unconstitutionality, laws which only presuppose the legality of abortion. *United States v. Salerno,* 481 U.S. 739, 745 (1987) (facial constitutional challenge must establish that no set of circumstances exist under which statute is valid).

CONCLUSION

There is no valid basis for excluding unborn children from the fundamental protections afforded all persons under the fourteenth amendment to the United States Constitution. This Court should therefore overrule. *Roe v. Wade,* 410 U.S. 113 (1973), and set this case for further briefing and reargument on the issue of the proper disposition of this appeal.

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AMICUS CURIAE

BRIEF

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

BERNARD J. TURNOCK, M.D., M.P.H., et al., - - - - - - - - - - - - - - - - - Appellants,

versus

RICHARD M. RAGSDALE, M.D., et al., - - - Appellees.

ON APPEAL FROM THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF OF FREE SPEECH ADVOCATES AS AMICUS CURIAE IN SUPPORT OF APPELLANTS

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TABLE OF CONTENTS

page

TABLE OF CONTENTS i
TABLE OF AUTHORITIES ii
INTEREST OF AMICUS iii
INTRODUCTION 1
SUMMARY OF ARGUMENT 2
ARGUMENT 4
I. ABORTION IS NOT A FUNDAMENTAL RIGHT . . 4
A. Those Who Assert New Fundamental Rights Must Bear the Burden of Establishing the Fundamental Nature of the Right. 5
B. Abortion Fails The Tests For Identifying Fundamen tal Rights. 7
1. Abortion bears no close relationship to existing fundamental rights. 9
2. Abortion is not implicit in the concept of ordered liberty. 11
3. Abortion is not deeply rooted in the history and tradition of this nation. 12
II. REGULATORY BURDENS ON ABORTION FACE NO MORE THAN MINIMAL SCRUTINY. 15
A. Abortion Is No More Than A Liberty Interest. . . . 15
B. Regulations Which Burden Liberty Interests Need Withstand Only Minimal Scrutiny. 17
III. THE ILLINOIS REGULATORY SCHEME EASILY PASSES CONSTITUTIONAL MUSTER 19
CONCLUSION 21

TABLE OF AUTHORITIES

Cases **page**

Adkins v. Children's Hospital, 261 U.S. 525 (1923) 15
Bowers v. Hardwick, 478 U.S. 186 (1986) . . . . . 2, passim
Ferguson v. Skrupa, 372 U.S. 726 (1963) 17, 18, 19
Griswold v. Connecticut, 381 U.S. 479 (1965) 6, 7, 8, 14, 15
Lochner v. New York, 198 U.S. 45 (1905) . . . 1, 6, 17, 19
Maher v. Roe, 432 U.S. 464 (1977) 10, 20
Meyer v. Nebraska, 262 U.S. 390 (1923) 14, 16
Michael H. v. Gerald D., 109 S. Ct. 2333 (1989) . . 5, 7, 8, 12, 16
Moore v. City of East Cleveland, 431 U.S. 494 (1977) . . . . . 3, passim
New Motor Vehicle Board v. Orrin W. Fox Co., 439 U.S. 96 (1978) 20
Palko v. Connecticut, 302 U.S. 319 (1937) 3, 9
People v. Belous, 71 Cal. 2d 954, 458 P.2d 194, 80 Cal. Rptr. 354 (1969), cert. denied, 397 U.S. 915 (1970) 11
Pierce v. Society of Sisters, 268 U.S. 510 (1925) 14
Poe v. Ullman, 367 U.S. 497 (1961) 7, 11, 14, 15
Ragsdale v. Turnock, 841 F.2d 1358 (7th Cir. 1988) 4, 19
Rice v. Norman Williams Co., 458 U.S. 654 (1982) 18
Roe v. Wade, 410 U.S. 113 (1973) . . . . . 2, passim
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Webster v. Reproductive Health Services, 109 S. Ct. 3040 (1989) 4, 10, 17
Williamson v. Lee Optical, 348 U.S. 483 (1955) 17

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Vieira, *Roe and Doe: Substantive Due Process and the Right of Abortion*, 25 Hastings L.J. 867 (1974) . . . 13

INTEREST OF AMICUS

Free Speech Advocates is a legal defense project that exists to secure the First Amendment rights to engage in religious witness, peaceful sidewalk counseling, and protest of or conscientious objection to the destruction of unborn human life. Free Speech Advocates endeavors to assure a proper and competent defense, due process, and all constitutional rights to those who take a stand against abortion.

Free Speech Advocates believes that judicial restraint and fidelity to the Constitution are essential to the preservation of genuine constitutional rights. When activist courts announce novel "fundamental rights" in a unprincipled manner, established constitutional rights suffer. This is so for a variety of reasons: first, judicially created rights dilute the significance of those rights the people have chosen to embody in the Constitution; second, judicially created rights may actually conflict with or limit existing rights; third, the illegitimate judicial creation of rights produces an atmosphere of reactive hostility to claims of constitutional rights, resulting in an unwillingness of courts to afford proper protection for genuine constitutional rights.

Thus, judicial invention of a "fundamental right to abortion" has led to the dilution of free speech and other rights, has directly impaired the right to life and the right of states to enact criminal and medical regulations, and has triggered an understandable backlash that threatens to impair judicial solicitude for legitimate constitutional claims.

Abortion is not a thread in the fabric of privacy rights. Rather, abortion is a malignant tumor on the body politic. Free Speech Advocates urges the Court to remove this cancerous growth before it further consumes the flesh and fiber of this nation.

The parties to the present case have consented to the filing of this brief. Letters granting consent are being submitted with this brief.

IN THE

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OCTOBER TERM, 1989

No. 88-790

BERNARD J. TURNOCK, M.D., M.P.H., et al., - - - - - - - - - - - - - - - - - Appellants,

versus

RICHARD M. RAGSDALE, M.D., et al., - - - Appellees.

INTRODUCTION

The decision of the court of appeals in this case presents a classic example, in the context of abortion jurisprudence, of the *Lochner* doctrine. In the long-discredited line of cases typified by *Lochner v. New York*, 198 U.S. 45 (1905), the Supreme Court applied an expansive concept of substantive due process to strike down a multitude of health, labor, and welfare regulations. The Court held such regulations to be unconstitutional, under the fourteenth amendment, insofar as they interfered with the unrestricted conduct of various businesses. In the present case, the lower court struck down a general scheme of health regulations for surgical facilities insofar as they interfered with the unrestricted conduct of the business of abortion.

The due process clause of the fourteenth amendment, however, does not confer regulatory immunity upon abortion entrepreneurs. Nor does that clause authorize the judiciary to undertake microscopic examination of any laws that stand in the way of abortion on demand.

This Court should clarify that abortion is not a fundamental right under the fourteenth amendment, and that the regulation and restriction of abortion is subject to no more than minimal judicial scrutiny.

SUMMARY OF ARGUMENT

The case at bar presents a constitutional challenge to various Illinois statutes and regulations governing surgical facilities. The lower court struck down these regulations, as applied to abortion businesses, holding that the regulations offended a substantive due process right to abortion under the fourteenth amendment. The lower court, however, erroneously applied a strict level of scrutiny; this Court should therefore reverse the judgment of the court of appeals.

Abortion is not a fundamental right under the due process clause of the fourteenth amendment. The alleged right appears nowhere in the text or design of the Constitution; hence, the proponents of such a right bear the burden of identifying the fundamental nature of their asserted claim.

As a matter of judicial restraint and adherence to the constitutional distribution of lawmaking authority, this Court should avoid creating novel constitutional rights. Before the Court will announce a right not previously recognized, the proponent of the alleged right must first satisfy the Court that the asserted claim meets the settled criteria for identifying fundamental constitutional rights.

Abortion fails the established trio of tests for determining fundamental rights.

First, abortion bears no close relationship to other, recognized fundamental rights, *Bowers v. Hardwick*, 478 U.S. 186, 190-91 (1986). The pregnant mother "cannot be isolated in her privacy," *Roe v. Wade*, 410 U.S. 113, 159 (1973); hence, abortion is "inherently different" from the "privacy" rights

previously recognized by this Court, *id.*

Second, abortion is not "implicit in the concept of ordered liberty," *Palko v. Connecticut*, 302 U.S. 319, 325 (1937). A free society does not presuppose abortion on demand. Indeed, the notion of abortion as a civil right is of extremely recent origin, and is highly controversial. The tradition of legal condemnation of abortion, furthermore, refutes any idea that abortion is essential to liberty.

Third, abortion is not "deeply rooted in this Nation's history and tradition," *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977). State statutes had prohibited abortion for a century or more prior to *Roe v. Wade*. Common law prohibitions and limitations on abortion technology combined to make abortion unavailable, in terms of safety and practicality, in the period prior to widespread legislation banning abortion. In no sense can abortion be said to possess a longstanding and respected tradition of practice.

Abortion therefore fails the tests for fundamentality under the due process clause of the fourteenth amendment. Consequently, abortion is no more than a general liberty interest — i.e., an activity that some may desire to engage in, but which receives no special constitutional recognition.

As a general liberty interest, abortion is subject to extensive regulation or restriction. Laws which burden mere liberty interests need no more than a rational basis to survive judicial review.

Judged under the deferential rational basis standard, the challenged Illinois health and medical regulations are patently constitutional.

ARGUMENT

This appeal presents a constitutional challenge to an Illinois regulatory scheme for ambulatory surgical facilities. The court of appeals struck down the relevant statutes and regulations as applied to facilities that provide abortions in the first and early second trimester of pregnancy. The appeals court reasoned as follows: first, any regulations which impose more than an insignificant burden on first trimester abortions are per se unconstitutional; and second, even regulations which impose only an insignificant burden on first trimester abortions are unconstitutional unless those regulations further a compelling government interest. *Ragsdale v. Turnock*, 841 F.2d 1358, 1368 (7th Cir. 1988).

The lower court erred in applying this super-strict standard of review. Abortion is not a "fundamental right" under the United States Constitution. At most, abortion is a general "liberty interest," *see Webster v. Reproductive Health Services*, 109 S. Ct. 3040, 3058 (1989) (plurality opinion). Hence, laws alleged to "burden" abortion face only minimal judicial scrutiny.

Under the proper standard of review, appellees' challenge to the Illinois regulatory scheme must fail.[1] This Court should therefore reverse the judgment of the court of appeals.

I. ABORTION IS NOT A FUNDAMENTAL RIGHT.

Abortion is not a fundamental right under the due process clause of the fourteenth amendment to the Constitution. The alleged right appears nowhere in the text of the Constitution.

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[1]This brief does not address the question whether the Illinois laws are unconstitutional, under the due process or equal protection clauses of the fourteenth amendment, insofar as they do not sufficiently protect the lives of unborn children. *See* Brief for Amici Curiae Catholics United for Life, *et al.*

Furthermore, those who would assert the existence of an abortion right cannot meet the burden of establishing such a claim. Abortion bears no relation to other, existing fundamental rights. Nor is permissive abortion implicit in the concept of ordered liberty or deeply rooted in the history and traditions of our country.

A. Those Who Assert New Fundamental Rights Must Bear the Burden of Establishing the Fundamental Nature of the Right.

A litigant who claims the protection of a novel and allegedly fundamental right under the fourteenth amendment bears the burden of demonstrating the fundamental nature of the asserted right. *Bowers v. Hardwick*, 478 U.S. 186, 195 (1986); *Michael H. v. Gerald D.*, 109 S. Ct. 2333, 2343 (1989) (plurality opinion).

Constitutional review represents an exercise of the "assumed power" of the judiciary "to set aside on grounds of unconstitutionality a state or federal statute representing the democratically expressed will of the people," *Thornburgh v. American College of Obstets. & Gynecs.*, 476 U.S. 747, 787 (1986) (White, J., dissenting). So long, however, as judicial review abides by the Constitution — itself an expression of the will of the people — constitutional adjudication "does not, in theory at any rate, frustrate the authority of the people to govern themselves," *id.*

A reviewing court, therefore, "is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution." *Bowers v. Hardwick*, 478 U.S. at 194. When constitutional adjudication proceeds beyond the textual boundaries of the document, the judiciary "takes to itself further authority to govern the country without express constitutional authority." *Id.* at 195. Extra-textual

judicial rulings "usurp the people's authority, for such decisions represent choices that the people have never made and that they cannot disavow through corrective legislation." *Thornburgh*, 476 U.S. at 787 (White, J., dissenting). Furthermore, decisions unbounded by textual limitations run the risk of becoming "extremely subjective and excessively discretionary determination[s]," *Griswold v. Connecticut*, 381 U.S. 479, 494 n.7 (1965) (Goldberg, J., concurring) (internal quotation marks and citation omitted), in which judges go "roaming at large in the constitutional field," *id.* at 502 (Harlan, J., concurring). "As the *Lochner* era demonstrates, there is reason for concern lest the only limits to such judicial intervention become the predilections of those who happen at the time to be Members of [the Supreme] Court." *Moore v. City of East Cleveland*, 431 U.S. 494, 502 (1977) (plurality opinion). "Use of any such broad, unbounded judicial authority would make of this Court's members a day-to-day constitutional convention." *Griswold*, 381 U.S. at 520 (Black, J., dissenting).[2]

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[2] St. Thomas Aquinas, in his *Summa Theologica*, listed three objections to judicial lawmaking, objections which are pertinent to adjudication in the area of substantive due process rights:

> As the Philosopher says (Rhet. i. I), *it is better that all things be regulated by law, than left to be decided by judges*: and this for three reasons. First, because it is easier to find a few wise men competent to frame right laws, than to find the many who would be necessary to judge aright of each single case. — Secondly, because those who make laws consider long beforehand what laws to make; Whereas judgment on each single case has to be pronounced as soon as it arises: and it is easier for man to see what is right, by taking many instances into consideration, than by considering one solitary fact. — Thirdly, because lawgivers judge in the abstract and of future events; whereas those who sit in judgment judge of things present, towards which they are affected by love, hatred, or some kind of cupidity; wherefore their judgment is perverted.

T. Aquinas, *Treatise on Law* 76 (Gateway Edition 1964) (*Summa Theologica*, Question 95, 1st art., Reply Obj. 2) (italics in original).

The remedy to judicial usurpation, of course, is judicial restraint. "No formula could serve as a substitute, in this area, for judgment and restraint." *Poe v. Ullman*, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting). As Justice Harlan wisely counseled in the *Griswold* case,

> Judicial self-restraint . . . will be achieved . . . only by continual insistence upon respect for the teachings of history, solid recognition of the basic values that underlie our society, and wise appreciation of the great roles that the doctrines of federalism and separation of powers have played in establishing and preserving American freedoms.

381 U.S. at 501 (concurring opinion) (citation omitted).

Thus, the "decision of an apparently novel claim must depend on grounds which follow closely on well-accepted principles and criteria." *Poe*, 367 U.S. at 544 (Harlan, J., dissenting). If the alleged constitutional right appears nowhere in the text or design of the Constitution, the claimant must bear the heavy burden of identifying the proposed right as fundamental under that Constitution. *E.g., Bowers*, 478 U.S. at 195 ("there should be . . . *great resistance* to expand . . . the category of rights deemed fundamental. . . . The claimed right pressed on us today falls far short of *overcoming this resistance*") (emphasis added); *Michael H. v. Gerald D.*, 109 S. Ct. at 2343 (plurality opinion) ("it is Michael's *burden to establish* that such a power [as he seeks to exercise] is . . . a fundamental right") (emphasis added); *id.* ("Michael asserts . . . a right . . . . What *he must establish*, therefore . . . ") (emphasis added).

B. Abortion Fails The Tests For Identifying Fundamental Rights.

The alleged "right" to abortion fails to satisfy the established tests for identifying fundamental rights under the fourteenth amendment.

Fundamental liberties and interests are most clearly present when the Constitution provides specific textual recognition of their existence and importance. The Constitution, however, obviously makes no mention of abortion, pregnancy, or reproduction in general.

It is true that although "the language of the Due Process Clause of the Fifth and Fourteenth Amendments . . . appears to focus only on the processes by which life, liberty, or property is taken," this Court has nonetheless repeatedly interpreted "those Clauses . . . to have substantive content," *Bowers v. Hardwick*, 478 U.S. 186, 191 (1986). In other words, the Court has read the due process clauses "to be broad enough to provide substantive protection against state infringement of a broad range of individual interests." *Thornburgh v. American College of Obstets. & Gynecs.*, 476 U.S. 747, 789 (1986) (White, J., dissenting) (citation omitted).

Substantive due process, however, is " 'a treacherous field for this Court.' " *Michael H. v. Gerald D.*, 109 S. Ct. 2333, 2341 (1989) (plurality opinion) (quoting *Moore v. City of East Cleveland*, 431 U.S. 494, 502 (1977) (plurality opinion)). " 'That the Court has ample precedent for the creation of new constitutional rights should not lead it to repeat the process at will.' " *Michael H.*, 109 S. Ct. at 2341 (plurality opinion) (quoting *Moore*, 431 U.S. at 544 (White, J., dissenting)).

In response to the danger of "unrestricted personal discretion" by judges in the identification of "basic and fundamental" rights, *Griswold v. Connecticut*, 381 U.S. 479, 494 n.7 (1965) (Goldberg, J., concurring), the Court has sought "to limit and guide interpretation of the [Due Process] Clause," *Michael H.*, 109 S. Ct. at 2341 (plurality opinion). The *Bowers* Court explained the judicial challenge as follows:

> Striving to assure itself and the public that announcing rights not readily identifiable in the Constitution's text involves much more than the imposition of the Justices' own choice of values on the States and the Federal Government, the Court has sought to identify the nature of the rights qualifying for heightened judicial protection.

478 U.S. at 191.

In particular, the Court has described three separate, but related tests for determining the existence of an allegedly fundamental right. First, does the asserted right bear a close relationship to recognized, existing constitutional rights? *Bowers*, 478 U.S. at 190-91. Second, is the asserted right " 'implicit in the concept of ordered liberty,' such that 'neither liberty nor justice would exist' " without that right? *Id.* at 191-92 (quoting *Palko v. Connecticut*, 302 U.S. 319, 325, 326 (1937)). Third, is the asserted right " 'deeply rooted in this Nation's history and tradition' "? *Bowers*, 478 U.S. at 192 (quoting *Moore*, 431 U.S. at 503 (plurality opinion)).

The alleged "right" to abortion fails under all three tests to qualify as a fundamental right under the due process clause of the fourteenth amendment.

1. Abortion bears no close relationship to existing fundamental rights.

Abortion bears no close relationship to existing, recognized fundamental rights. In *Roe v. Wade*, 410 U.S. 113 (1973), this Court acknowledged that the asserted "right" to abortion involves a situation "inherently different from marital intimacy, . . . or marriage, or procreation," *id.* at 159, for the simple reason that the "pregnant woman cannot be isolated in her privacy," *id.* "She carries . . . the developing young in the human uterus." *Id.* Abortion involves the deliberate destruction of "a form of

human life," *Webster v. Reproductive Health Services*, 109 S. Ct. 3040, 3058 (1989) (plurality opinion), and thus bears no resemblance to any other constitutional right whatsoever. *See also Maher v. Roe*, 432 U.S. 464, 480 (1977) ("other medical procedures . . . do not involve the termination of a potential life"). As Justice White observed in his *Thornburgh* dissent:

> [T]he issues in the [other privacy cases] differ from those at stake where abortion is concerned. . . . [T]he termination of a pregnancy typically involves the destruction of another entity: the fetus. . . . Given that the continued existence and development — that is to say, the *life* — of such an entity are so directly at stake in the woman's decision whether or not to terminate her pregnancy, that decision must be recognized as sui generis, different in kind from the others that the Court has protected under the rubric of personal or family privacy and autonomy.

Thornburgh, 476 U.S. at 792 (emphasis in original) (footnote omitted). By analogy, to borrow Justice White's example, "parents have a fundamental liberty to make decisions with respect to the upbringing of their children," but "no one would suggest that this fundamental liberty extends to assaults committed upon children by their parents." *Id.* at 792 n.2.

As in the *Bowers* case, "none of the rights announced in [prior] cases bears any resemblance to the claimed constitutional right" at issue here. 478 U.S. at 190-91. "No connection between family, marriage, or procreation on the one hand and [the asserted right] on the other has been demonstrated," *id.* at 191; on the contrary, abortion, if anything, is the negation of these fundamental elements of society.

The alleged "right" to abort one's offspring thus fails the first test for identifying fundamental rights.

2. Abortion is not implicit in the concept of ordered liberty.

Abortion also fails the second test for fundamental rights: it is not "implicit in the concept of ordered liberty."

One cannot seriously claim that "a free, egalitarian, and democratic society" presupposes abortion on demand. *Thornburgh*, 476 U.S. at 793 (White, J., dissenting). No state constitutional bill of rights even mentions abortion, much less explicitly endorses permissive abortion laws. Neither the founders of our nation, nor the framers of the Constitution, nor the authors of the fourteenth amendment made any impassioned pleas for a right to abortion. No patriots shed their blood at Lexington or Valley Forge to win the freedom to destroy the unborn. No states have seceded or taken up arms because of laws forbidding abortion.

Moreover, the notion of abortion as a civil liberty is of very recent currency.[3] As late as the 1961 decision of *Poe v. Ullman*, 367 U.S. 497 (1961), Justice Harlan perceived no inherent difficulty with state authority to legislate "on adult consensual homosexuality, abortion, and sterilization, or euthanasia and suicide," *id.* at 547 (Harlan, J., dissenting) (emphasis added). While the social, moral, and political controversy surrounding abortion may have been spreading even as Justice Harlan wrote, it was only in the wake of the social upheaval of the 1960's that the loosening of abortion laws became a reality. In fact, no court

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[3] *See generally* Dellapenna, *The History of Abortion: Technology, Morality, and Law*, 40 U. Pitt. L. Rev. 359, 407-11 (1979). Professor Dellapenna traces the origins of political opposition to abortion restrictions to leftist movements acting in the period immediately following World War I. Id. at 407-09. Statutory changes favorable to permissive abortion began in this country in the late 1960's. Id. at 411 n.326. The first judicial invalidation of abortion restrictions in the United States was in California in 1969. Id. at 411 n.327 (citing *People v. Belous*, 71 Cal. 2d 954, 458 P.2d 194, 80 Cal. Rptr. 354 (1969), *cert. denied*, 397 U.S. 915 (1970)).

appears to have overturned any abortion restrictions prior to 1969, just four years before *Roe* itself. *See* 410 U.S. at 154-55 (listing cases invalidating or sustaining abortion statutes).

Indeed, unless various Members of this Court, the President of the United States, a multitude of federal and state legislators, the Republican party, and an entire segment of the population of this country are to be branded as hostile to a basic freedom, abortion cannot be considered implicit in the concept of ordered liberty.

Furthermore, a history of legal prohibition of an activity suffices to refute any claim that the freedom to engage in that activity is implicit in the concept of ordered liberty. *Bowers v. Hardwick*, 478 U.S. at 192-94; *Michael H.*, 109 S. Ct. at 2341 n.2 (plurality opinion) (showing of fundamentality "must at least exclude . . . a societal tradition of enacting laws denying the interest") (emphasis deleted). As discussed below, *see infra* § I(B)(3), the history of abortion law confirms that abortion is not a fundamental right.

Abortion thus fails the second test for identifying fundamental rights.

3. Abortion is not deeply rooted in the history and tradition of this nation.

Finally, abortion wholeheartedly fails the third test for fundamental rights: an abortion liberty is not "deeply rooted in this Nation's history and tradition."

The *Roe* Court devoted extensive treatment to the history of abortion law, attempting to limit the scope and import of laws that had banned abortion for at least a century. 410 U.S. at 129, 132-41, 147-49, 151-52, 160-62. This historical analysis has been the target of severe scholarly criticism, *see, e.g.*, Dellapenna, *supra* note 3; Byrn, *An American Tragedy: The Supreme Court on Abortion*, 41 Fordham L. Rev. 807, 814-39

(1973); Vieira, *Roe and Doe: Substantive Due Process and the Right of Abortion*, 25 Hastings L.J. 867, 873-74 (1974). Moreover, even on its own terms, the *Roe* opinion refutes any notion of a longstanding tradition of freedom to abort.

The *Roe* Court admitted that statutes banning abortion date back at least to the latter half of the nineteenth century, 410 U.S. at 129, 139 — i.e., precisely the time when the fourteenth amendment was adopted.[4]

Roe concludes that the absence of abortion statutes before their widespread enactment in the 1800's meant that, in the period prior to such legislation, "a woman enjoyed a substantially broader right to terminate a pregnancy" than at the time of *Roe*. *Id.* at 140. This conclusion, however, not only ignores the common law restrictions on abortion, *see* Dellapenna, *supra* note 3, at 376-92, but more importantly disregards the fact that, medically speaking, abortion techniques were either ineffective or so dangerous as to be practically suicidal, *id.* at 371-76. Abortion simply was not a safe or practical alternative. Indeed, it would be bizarre to assume that abortion, admittedly "hazardous" in the 1800's, *Roe*, 410 U.S. at 148, had been a matter of frequent recourse prior to that time. The more obvious conclusion is that this "hazardous" (and, for the unborn child, lethal) practice first began to be a matter of significant frequency in the nineteenth century, Dellapenna, *supra* note 3, at 394-95, 411-12 (technological refinements, beginning from about the year 1750, progressively reduced the risks to the mother, enabling greater recourse to abortion), and that the immediate response of statutory condemnation represented the repudiation of a relatively new social phenomenon, *id.* at 395.

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[4] *Roe* also concedes that in England all abortions were banned by statute in 1803, *id.* at 136, and that from 1837 until the loosening of English abortion law in 1967, the same degree of penalties applied to abortions regardless of the stage of pregnancy, *id.*

In any event, the century of undisputed statutory condemnation of abortion, coupled with the novelty of claims that abortion is a constitutional right, make it abundantly clear that abortion is by no means "deeply rooted in this Nation's history and tradition."

It simply cannot be seriously argued that abortion falls among the class of "rights long freely enjoyed," *Meyer v. Nebraska*, 262 U.S. 390, 403 (1923), that abortionists are "engaged in a kind of undertaking not inherently harmful, but long regarded as useful and meritorious," *Pierce v. Society of Sisters*, 268 U.S. 510, 534 (1925), that unrestricted abortion practices "form a pattern so deeply pressed into the substance of our social life that any Constitutional doctrine in this area must build upon this basis," *Poe v. Ullman*, 367 U.S. 497, 546 (1961) (Harlan, J., dissenting), that abortion is "an institution which the State not only must allow, but which always and in every age it has fostered and protected," *id.* at 553, that liberal abortion is "as old and as fundamental as our entire civilization," *Griswold*, 381 U.S. at 496 (Goldberg, J., concurring), that abortion "reflects a strong tradition founded on the history and culture of Western civilization [and] now established beyond debate as an enduring American tradition," *Moore*, 431 U.S. at 503 n.12 (plurality opinion), or that permissive abortion reflects "the accumulated wisdom of civilization, gained over the centuries and honored throughout our history," *id.* at 505. Merely to recite these various phrasings of the test of historical tradition is to demonstrate the absurdity of a claim that abortion satisfies this test. Such a claim "is, at best, facetious," *Bowers*, 478 U.S. at 194, and would make a mockery of the respected traditions among which abortion seeks legal company.

Abortion thus fails the third and final test for identifying fundamental rights under the due process clause of the fourteenth amendment. If anything, abortion is an activity "which

the law has always forbidden and which can have no claim to social protection," *Poe*, 367 U.S. at 553 (Harlan, J., dissenting). *Accord Roe*, 410 U.S. at 174-77 (Rehnquist, J., dissenting) (noting multitude of laws against abortion at time of adoption of fourteenth amendment).

Under the established tests for identifying the nature of rights under the due process clause, the claim that there exists a fundamental abortion right must fail.

II. REGULATORY BURDENS ON ABORTION FACE NO MORE THAN MINIMAL SCRUTINY.

Laws which regulate or impose restrictions on abortion face no more than minimal judicial scrutiny under the due process clause. Abortion is no more than a general liberty interest; thus, burdens on that "liberty" trigger no more than judicial review for rationality.

A. Abortion Is No More Than A Liberty Interest.

Abortion is not a fundamental right. *See supra* § I. Hence, abortion is entitled to no more constitutional protection than that due a general "liberty interest."

The term "liberty" has, of course, a very broad meaning. Any activity may be considered a "liberty interest" so long as it is " 'merely an example of doing what you want to do, embodied in the word liberty.' " *Griswold*, 381 U.S. at 518 n.11 (Black, J., dissenting) (quoting *Adkins v. Children's Hospital*, 261 U.S. 525, 568 (1923) (Holmes, J., dissenting)). Thus, one may have a liberty interest in such activities as driving a motorcycle without a helmet, or smoking cigarettes, or owning a pit bull, or obtaining a face lift.

"Liberty interest," then, is the label for the general category of activities in which a person may wish to engage. *See Moore*, 431 U.S. at 502 (plurality opinion) (quoting *Poe*, 367 U.S. at 543) (" 'the liberty guaranteed by the Due Process Clause . . .

is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints' "); *Meyer*, 262 U.S. at 399 ("liberty . . . denotes not merely freedom from bodily restraint but also the right of the individual to contract, to engage in any of the common occupations of life, to acquire useful knowledge, to marry, establish a home and bring up children, to worship God according to the dictates of his own conscience, and generally to enjoy those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men").

Among this broad class of liberty interests are fundamental rights; such rights, however, represent a special, and distinctly limited class of liberty interests. *Moore*, 431 U.S. at 502 (plurality opinion) ("certain substantive liberties," the identification of which is limited by "caution and restraint," receive special status); *id.* at 537 (Stewart, J., dissenting) (only in "rare cases" are the "personal interests at issue" deemed "fundamental"); *id.* at 544, 546-50 (White, J., dissenting) (fundamental rights only form part of broad range of liberty interests); *cf. Bowers*, 478 U.S. at 195 ("there should be . . . great resistance to expand the substantive reach of . . . the category of rights deemed to be fundamental"). Abortion is not one of these extraordinary, fundamental rights. *See* § I.

It is not obvious that abortion even qualifies as a general liberty interest. For if there is a "liberty interest" in committing a traditional crime like abortion, then there presumably also would be a liberty interest in other "assaults committed upon children by their parents," *Thornburgh*, 476 U.S. at 792 n.2 (White, J., dissenting), as well as "a liberty interest in firing a gun . . . into another person's body," *Michael H.*, 109 S. Ct. at 2342 n.4. If this be the case, the term "liberty interest" becomes so expansive as to lose all value as a definitional term.

In any event, however, it is at least clear that abortion qualifies as no more than a mere general liberty interest. *Accord Webster*, 109 S. Ct. at 3058 (plurality opinion).

B. Regulations Which Burden Liberty Interests Need Withstand Only Minimal Scrutiny.

A law that burdens the exercise of a general liberty interest (i.e., an interest that is not a fundamental right) triggers only minimal judicial scrutiny. The law is constitutional if it has a rational basis to support it. *Bowers*, 478 U.S. at 196; *Ferguson v. Skrupa*, 372 U.S. 726 (1963); *Williamson v. Lee Optical*, 348 U.S. 483, 488 (1955) ("It is enough that there is an evil at hand for correction, and that it might be thought that the particular legislative measure was a rational way to correct it").

This deferential standard of review for general liberty interests represents a firm repudiation of "a time when the Due Process Clause was used by this Court to strike down laws which were thought unreasonable, that is, unwise or incompatible with some particular economic or social philosophy." *Ferguson*, 372 U.S. at 729. The extensive scrutiny that characterized such cases as *Lochner v. New York*, 198 U.S. 45 (1905) (overturning law setting maximum hours for work in bakeries), led to a "painful[] . . . face-off between the Executive and the Court in the 1930's, which resulted in repudiation of much of the substantive gloss that the Court had placed on the Due Process Clauses of the Fifth and Fourteenth Amendments." *Bowers*, 478 U.S. at 194-95.

The appropriate, relaxed standard of review thus reflects "the original constitutional proposition that courts do not substitute their social and economic beliefs for the judgment of legislative bodies, who are elected to pass laws." *Ferguson*, 372 U.S. at 730. "The Due Process Clause does not authorize this Court to assess the wisdom of [a state l]egislature's decision,"

absent a "constitutionally protected [i.e., fundamental] liberty . . . interest," *Rice v. Norman Williams Co.*, 458 U.S. 654, 664 (1982).

It may be that, in the absence of restrictions on a fundamental right, state laws need not even undergo the scrutiny entailed in the rational relationship test. *Compare Rice*, 458 U.S. at 664 (refusal to assess wisdom of legislation) *and Ferguson*, 372 U.S. at 730-32 (legislative judgment "no concern of ours") *with id.* at 733 (Harlan J., concurring in judgment) (applying rational relationship test) *and Moore*, 431 U.S. at 547-48 (White, J., dissenting) (legislation still subject to "a means-ends test as a matter of substantive due process law," though "substantive review is indeed mild"). In *Bowers v. Hardwick*, the Court noted — without agreeing or disagreeing — that "respondent *asserts* that there must be a rational basis for the law," 478 U.S. at 196 (emphasis added); the Court, however, merely declined to hold that the "presumed" moral beliefs of the electorate were "an inadequate rationale," *id.* "The law," said the Court, "is constantly based on notions of morality, and if all laws representing essentially moral choices are to be invalidated under the Due Process Clause, the courts will be very busy indeed." *Id.*

Thus, it is clear that laws that limit a general liberty interest, whether they be characterized as "prohibitory" or merely "regulatory," *Ferguson*, 372 U.S. at 732, need not undergo scrutiny on the basis of their alleged necessity or wisdom, *id.* at 730-32; *Rice*, 458 U.S. at 664. Such a law, if duly enacted and not excessively vague, *Moore*, 431 U.S. at 547 (White, J., dissenting), is constitutional if it has an arguably rational basis. No higher level of scrutiny is warranted absent an infringement on some fundamental right.

Hence, laws interfering with abortion practices trigger no more than minimal judicial scrutiny.

III. THE ILLINOIS REGULATORY SCHEME EASILY PASSES CONSTITUTIONAL MUSTER.

The Illinois statutes and regulations at issue here easily survive the minimal judicial review appropriate for substantive due process analysis. Abortion is not a fundamental right; hence, no higher level of scrutiny is warranted on that basis.[5]

The challenged regulatory scheme imposes a variety of health requirements on surgical facilities in general and abortion businesses in particular. These requirements relate to such matters as physical plant structure, access to emergency treatment, informed consent for patients, and staff qualifications. The challenged laws, in short, represent classic examples of state regulation of medical practices.

Contrary to the decision of the court below, *Ragsdale v. Turnock*, 841 F.2d 1358, 1368 (7th Cir. 1988), there is no requirement of "medical necessity" for these regulations. The necessity and wisdom of laws is a matter for the legislature, not the federal courts. When the lower court inquired whether the challenged regulations were "inappropriate," *id.* at 1370, "troubling," *id.* at 1373, or "contrary to sound health policy," *id.* at 1371, the court improperly went "back to the time when courts used the Due Process Clause to strike down state laws, regulatory of business and industrial conditions, because they may be unwise, improvident, or out of harmony with a particular school of thought." *Ferguson,* 372 U.S. at 731-32 (internal quotation marks and citation omitted).

The days of *Lochner*, however, are over. When the court of appeals indulged in this quintessential "Lochnerizing," the court strayed from its proper constitutional function. "The due process clause is not to be so broadly construed that the Con-

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[5] This brief does not address alternative bases for applying strict scrutiny, such as the impairment of the right to life and equal protection of unborn persons. *See* Brief of Catholics United for Life, *et al.*

gress and state legislatures are put in a strait jacket when they attempt to suppress business and industrial conditions which they regard as offensive to the public welfare." *New Motor Vehicle Board v. Orrin W. Fox Co.*, 439 U.S. 96, 107 (1978) (internal quotation marks, brackets, and citations omitted).

There can be no serious claim that the Illinois regulatory scheme does not reflect an arguable health care rationale. Furthermore, even if all that the regulations did was to hinder the practice of abortion, the regulations still would reflect a legitimate state goal — namely, the deterring of a disfavored activity. *See Bowers*, 478 U.S. at 196; *Webster*, 109 S. Ct. at 3050 ("*Roe v. Wade* 'implies no limitation on the authority of a State to make a value judgment favoring childbirth over abortion' ") (quoting *Maher v. Roe*, 432 U.S. 464, 474 (1977)).

The Illinois statutes and regulations clearly do not violate any substantive due process rights under the fourteenth amendment.

CONCLUSION

The court of appeals improperly applied the *Lochner* standard of substantive due process review. Under the correct, deferential standard of scrutiny, the challenged Illinois statutes and regulations do not violate the due process clause of the fourteenth amendment.

This Court should therefore reverse the judgment of the court of appeals.

Respectfully submitted,

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BRIEF

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Supreme Court of the United States

OCTOBER TERM, 1989

BERNARD J. TURNOCK, M.D., M.P.H.,
Director of the Illinois Department
of Public Health, *et al.*,
Appellants,

v.

RICHARD M. RAGSDALE, M.D., *et al.*,
Appellees.

On Appeal from the United States Court of Appeals for the Seventh Circuit

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BRIEF OF CERTAIN ILLINOIS SENATORS AND REPRESENTATIVES AS *AMICI CURIAE* IN SUPPORT OF APPELLANTS

[Amici listed inside front cover]

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF THE *AMICUS CURIAE*	1
SUMMARY OF ARGUMENT	2
ARGUMENT	4
I. THE AMBULATORY SURGICAL TREATMENT CENTER ACT WAS ENACTED IN 1973 TO REGULATE ALL OUTPATIENT SURGICAL FACILITIES AND NOT TO RESTRICT ACCESS TO ABORTION	5
II. THE ILLINOIS HEALTH FACILITIES PLANNING ACT WAS ENACTED IN 1974 TO CONTROL THE COST OF HEALTH CARE FACILITIES AND NOT TO REGULATE ABORTION	12
III. THE AMBULATORY SURGICAL TREATMENT CENTER ACT AND THE REGULATIONS ADOPTED BY THE DEPARTMENT OF PUBLIC HEALTH WERE SUBSTANTIALLY AMENDED IN 1979 IN DIRECT RESPONSE TO A *CHICAGO SUN-TIMES* AND BETTER GOVERNMENT ASSOCIATION INVESTIGATION OF CHICAGO ABORTION CLINICS IN 1978	14
IV. IN STRIKNG DOWN THE AMBULATORY SURGICAL TREATMENT CENTER ACT AND THE REGULATIONS ADOPTED THEREUNDER, THE COURT OF APPEALS ERRED IN RELYING UPON THE "LEGISLATIVE MOTIVE" DOCTRINE OF *THORNBURGH v. AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS*, WHICH THIS COURT SHOULD EXPRESSLY ABANDON	24
CONCLUSION	30
APPENDIX	1a
LODGED DOCUMENTS	(Separately Bound)

TABLE OF AUTHORITIES

CASES

	Page
Aldridge v. Williams, 44 U.S. (3 Howard) 15 (1845)	26
Arlington Heights v. Metropolitan Housing Development Corp., 429 U.S. 252 (1977)	28
Arizona v. California, 283 U.S. 423 (1930)	26
Boos v. Barry, 108 S.Ct. 1157 (1988)	27
Brooklyn Union Gas Co. v. Standard Oil Co., 391 U.S. 366 (1968)	26
City of Renton v. Playtime Theatres, Inc., 475 U.S. 41 (1986)	27
County of Alleghany v. American Civil Liberties Union, 109 S.Ct. 3086 (1989)	28
Dakota Central Tel. Co. v. South Dakota, 250 U.S. 163 (1918)	26
Daniel v. Family Ins. Co., 336 U.S. 220 (1948)	26
Doe v. Bolton, 410 U.S. 179 (1973)	7
Doyle v. Continental Ins. Co., 94 U.S. 535 (1877)	26
Edwards v. Aguillard, 482 U.S. 578 (1987)	27, 28
Epperson v. Arkansas, 393 U.S. 97 (1968)	28
Felix v. Young, 536 F.2d 1126 (6th Cir. 1976)	27
Fletcher v. Peck, 10 U.S. (6 Cranch) 87 (1810)	25, 26
Fraternal Order of Police Hobart Lodge No. 121, Inc. v. City of Hobart, 864 F.2d 551 (7th Cir. 1988)	27
Hamilton v. Kentucky Distilleries Co., 251 U.S. 146 (1919)	26
Hedd Surgi-Center, Inc. v. Turnock, 711 F. Supp. 439 (N.D. Ill. 1989)	4, 5
Hodgson v. Minnesota, 648 F. Supp. 756 (D. Minn. 1986), *rev'd on other grounds*, 853 F.2d 1452 (8th Cir. 1988)	29
Hunter v. Underwood, 471 U.S. 222 (1985)	28
Lemon v. Kurtzman, 403 U.S. 602 (1971)	28
Margaret S. v. Edwards, 794 F.2d 994 (5th Cir. 1986)	29
McCray v. United States, 195 U.S. 27 (1904)	25, 26
Palmer v. Thompson, 403 U.S. 217 (1971)	27
Personnel Administrator v. Feeney, 442 U.S. 256 (1979)	28

TABLE OF AUTHORITIES—Continued

	Page
Planned Parenthood Ass'n of Kansas City, Mo., Inc. v. Ashcroft, 462 U.S. 476 (1983)	15
Ragsdale v. Turnock, 625 F. Supp. 1212 (N.D. Ill. 1985)	4, 5
Ragsdale v. Turnock, 841 F.2d 1358 (7th Cir. 1988), *juris. post.*, 109 S.Ct. 3239 (1989)	*passim*
Roe v. Wade, 410 U.S. 113 (1973)	7, 11, 17, 18
Sipes v. United States, 321 F.2d 174 (8th Cir. 1963)	27
Smith v. Kansas City Title & Trust Co., 255 U.S. 180 (1921)	26
Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747 (1986)	*passim*
Torres v. Delgado, 510 F.2d 1182 (1st Cir. 1975)	27
United States v. Des Moines Nav. & Ry. Co., 142 U.S. 510 (1892)	26
United States v. Doremus, 249 U.S. 86 (1919)	26
United States v. O'Brien, 391 U.S. 367 (1967)	25, 26
United States v. Ross, 458 F.2d 1144 (11th Cir. 1972)	27
Village of Oak Lawn v. Marcowitz, 86 Ill.2d 406, 427 N.E.2d 36 (1981)	6
Wall Distributors, Inc. v. City of Newport News, 782 F.2d 1165 (4th Cir. 1986)	27
Wallace v. Jaffree, 472 U.S. 38 (1985)	28
Washington v. Davis, 426 U.S. 229 (1976)	27
Weber v. Fried, 239 U.S. 325 (1915)	26
Webster v. Reproductive Health Services, Inc., 109 S.Ct. 3040 (1989)	18
Western Airlines v. Board of Equalization of South Dakota, 107 S.Ct. 1038 (1987)	6
Wilderness Society v. Morton, 479 F.2d 842 (D.C. Cir. 1973)	27
Wilson v. New, 243 U.S. 332 (1917)	26

STATUTES

Ambulatory Surgical Treatment Center Act (ASTCA), Ill. Rev. Stat., ch. 111½, par. 157-8.1 *et seq.* (1987)	*passim*

TABLE OF AUTHORITIES—Continued

	Page
The Illinois Health Facilities Planning Act, Ill. Rev. Stat., ch. 111½, par. 1151 *et seq.* (1987)	*passim*
Medical Practice Act, Ill. Rev. Stat., ch. 111, par. 4433(1) (1987)	5
77 Ill. Admin. Code, sec. 205.730(a)(2)	18
Illinois Register (various dates)	17, 23, 24

LEGISLATIVE HISTORY

House Bill 634, 76th Ill. Gen. Assem. (1969)	11, 18
House Bill 663, 76th Ill. Gen. Assem. (1969)	11
House Bill 1407, 76th Ill. Gen. Assem. (1969)	10, 11
Senate Bill 1049, 78th Ill. Gen. Assem. (1973)	10, 11
Senate Bill 1050, 78th Ill. Gen. Assem. (1973)	10, 11
Senate Bill 1051, 78th Ill. Gen. Assem. (1973)	*passim*
Senate Bill 676, 81st Ill. Gen. Assem. (1979)	17, 22, 23
House Bill 438, 81st Ill. Gen. Assem. (1979)	*passim*
80th Illinois General Assembly, Report to the House Human Resources Committee, Subcommittee on Health, "State regulation of abortion clinics," Dec. 13, 1978	16-17
Legislative Synopsis and Digest, 1973 Sess., 78th Ill. Gen. Assem.	7
78th Ill. Gen. Assem., Senate Proceedings (various dates)	*passim*
78th Ill. Gen. Assem., House Proceedings (various dates)	*passim*
81st Ill. Gen. Assem., Senate Proceedings (various dates)	22, 23
81st Ill. Gen. Assem., House Proceedings (various dates)	*passim*
Illinois House Journal (1969)	11
Illinois Senate Journal (1973)	10, 11
Illinois House Journal (1973)	11

MISCELLANEOUS

"The Abortion Profiteers," *Chicago Sun-Times*—Better Government Association special investigative series, *Chicago Sun-Times*, November 12, 1978 and following dates	*passim*

TABLE OF AUTHORITIES—Continued

	Page
Bovbjerg, *Problems and Prospects for Health Planning: The Importance of Incentives, Standards, and Procedures in Certificate of Need*, 1978 Utah. L. Rev. 83	14
L. Burns, *Ambulatory Surgery: Developing and Managing Successful Programs* (1984)	7
Symposium: Certificate of Need Laws in Health Planning, 1978 Utah L. Rev. 1	14

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INTEREST OF THE *AMICI*

Amici Curiae constitute a bipartisan group of Illinois legislators with differing views on abortion as public policy. All of the *amici curiae*, however, support the authority of state legislatures and administrative agencies to regulate outpatient surgical facilities to promote public health and protect the lives of women undergoing abortions. After a five-month investigation, the *Chicago-Sun-Times* and the Better Government Association published a series of articles entitled, "The Abortion Profiteers," in November 1978, which disclosed that at least twelve women had died following abortions in Chicago abortion clinics; that abortions were performed under unsterile conditions, on women who were not pregnant, or without

anesthesia; that patients were forced to leave the recovery room prematurely, that medical records were falsified; and that kickbacks were paid for abortion referrals. This investigation raised such a public outcry over the conditions and practices in Illinois abortion clinics that state officials were compelled to respond with appropriate regulatory oversight.

In declaring these statutes and regulations unconstitutional because of the presumed bad "motive" of the legislators (*i.e.*, to regulate abortion), the court of appeals ignored compelling evidence of the need for regulatory control of outpatient surgical facilities in 1973, and the need for more intensive regulation of abortion clinics discovered in 1978. To uphold the constitutional authority of public officials to address these public health needs, *amici curiae* submit this brief in support of Appellants.*

SUMMARY OF THE ARGUMENT

This Court has long held that States have broad authority to regulate the practice of medicine under their police powers. In enacting the Ambulatory Surgical Treatment Center Act (ASTCA) in 1973, the Illinois General Assembly sought to provide better and less expensive health care by authorizing outpatient surgical facilities, including abortion clinics. The bill creating the Act was drafted and supported by the Illinois State Medical Society. Many other States have also authorized ambulatory surgical treatment centers or free-standing outpatient facilities in an effort to ensure more economical health care for their citizens.

The Ambulatory Surgical Treatment Center Act was supported by abortion-rights proponents. Some abortion opponents supported the ASTCA; others opposed it because they believed that the Act would foster abortion on demand. There is no evidence in the legislative history

* Letters of consent from both parties of record to the filing of this brief have been filed with the clerk.

that any abortion opponents favored the ASTCA because they believed that it would restrict abortion.

The Illinois Health Facilities Planning Act (IHFPA) was enacted in 1974 to promote the efficient planning of new health facilities, including ASTC's. Like many States, the IHFPA required a certificate of need for new health facilities. The IHFPA was also supported by abortion-rights proponents.

In 1979, the ASTCA and the regulations promulgated thereunder were amended, as a direct result of the November, 1978, *Chicago Sun-Times* exposé, "The Abortion Profiteers." Those amendments were sponsored and supported by abortion proponents in an effort to remedy the abuses revealed in the *Sun-Times* series. The abortion-specific regulations were intended to address particular abuses that were discovered in the clinics' practices.

In holding that ambulatory surgical treatment centers that perform first and early second trimester abortions are not subject to regulation, the Seventh Circuit seriously erred. A critical element in the court's decision was its conclusion that the ASTCA and the IHFPA were influenced by an impermissible "legislative motive," *i.e.*, to restrict abortion. This conclusion was based solely on the minutes of three meetings of the licensing board created by the ASTCA, evidence which had nothing to do with the creation and enactment of the 1973 act, the 1974 act, or the 1979 amendments, and which the trial court expressly refused to admit as proof of the legislature's intent. The court's analysis reflects not only inaccurate legislative history, but poor constitutional law. Except in a few narrow circumstances not relevant here, this Court has consistently repudiated the doctrine that legislative motive may be considered in determining the constitutionality of a statute. To the extent that the court of appeals may have found support for its reliance upon legislative motive in *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986), that as-

pect of *Thornburgh* should be expressly abandoned. To strike down statutes that are otherwise constitutional on the basis of the alleged motivations of the legislators is unprincipled in theory, unprecedented in practice and unacceptable in a democratic society.

ARGUMENT

> I am persuaded . . . that under *Roe* and its progeny a state not only has the power and authority, but also the duty, to regulate all medical facilities, particularly any facility where any surgical procedures are performed (including first-trimester abortions) as a valid exercise of its interest in protecting the health and welfare of its citizens while ensuring that the facilities will provide "conditions insuring maximum safety for the woman" who had decided to terminate her pregnancy. *Connecticut v. Menillo*, 423 U.S. at 11, 96 S.Ct. at 171.
>
> *Ragsdale v. Turnock*, 841 F.2d 1358, 1388 (7th Cir. 1988) (Coffey, J., dissenting).

This is an appeal from a judgment of the Court of Appeals for the Seventh Circuit holding that statutes and administrative rules regulating outpatient surgical facilities in the interest of public health may not be applied to those facilities which perform first- and early second-trimester abortions. *Ragsdale v. Turnock*, 625 F.Supp. 1212 (N.D.Ill. 1985), *aff'd in part, rev'd in part*, 841 F.2d 1358 (7th Cir. 1988), *juris. post.*, 109 S.Ct. 3239 (1989).[1]

[1] Although technically the court of appeals affirmed a preliminary injunction issued by the district court, the Seventh Circuit considered the statutes and regulations to be unconstitutional as a matter of law and refused to sever any of the provisions struck down. *Ragsdale*, 841 F.2d at 1371. Both the district court judge and the parties in subsequent litigation have understood the Seventh Circuit to have declared the regulations to be unconstitutional in their application to abortion clinics. *See Hedd Surgi-Center, Inc. v. Turnock*, 711 F. Supp. 439, 443 & n.6, 444 (N.D.Ill. 1989).

The regulatory scheme derives from the Ambulatory Surgical Treatment Center Act (ASTCA), Ill. Rev. Stat., ch. 111½, par. 157-8.1 *et seq.* (1987); the Illinois Health Facilities Planning Act (IHFPA), Ill. Rev. Stat., ch. 111½, par. 1151 *et seq.* (1987); and the Medical Practice Act (MPA), Ill. Rev. Stat., ch. 111, par. 4433(1) (1987). The original statutes and regulations were enacted in 1973 and 1974. Some of the regulations have not been enforced due to intervening judicial decisions. *See Ragsdale*, 841 F.2d at 1363-64.

The district court entered a preliminary injunction against enforcement of the regulations to the extent that they apply to outpatient surgical facilities that perform first and early second trimester abortions, holding that the appropriate standard of review was whether the state could articulate a "compelling need" for the scheme and could show that the regulations were "medically necessary." *Ragsdale*, 625 F.Supp. at 1229-30. *See also Hedd Surgi-Center, Inc. v. Turnock*, 711 F.Supp. 439, 444 n. 8 (N.D.Ill. 1989).

The court of appeals affirmed the district court's preliminary injunction, as well as the "medical necessity" standard of review. *Ragsdale*, 841 F.2d at 1368.

I. THE AMBULATORY SURGICAL TREATMENT CENTER ACT WAS ENACTED IN 1973 TO REGULATE ALL OUTPATIENT SURGICAL FACILITIES AND NOT TO RESTRICT ACCESS TO ABORTION.

The court of appeals held that the Ambulatory Surgical Treatment Center Act could not be applied to outpatient surgical facilities that perform first- and early second-trimester abortions because "the State may not require separate licensure of facilities primarily devoted to performing abortions." *Id.* at 1371. The court applied the strict scrutiny standard of judicial review because it found that the statute had been enacted "primarily with abortion clinics in mind and only applied to

outpatient surgical clinics generally in an effort to save the statute from unconstitutionality." *Id.* at 1369.[2]

In support of this finding, the majority opinion relied exclusively on unattributed statements recorded in the minutes of the licensing board created by the Act. *Id.*, citing plaintiff's exhibits 22 to 24. As Judge Coffey noted in his dissent, however, "*the district court specifically . . . rejected the plaintiff's request to admit the minutes of the licensing board meeting as proof of the legislature's intent.*" *Id.* at 1379 n. 9, citing the trial transcript at 616 (emphasis in original).[3]

The district court's ruling was clearly proper because " 'a court should adhere to the enacting legislature's purposes,' Posner, *The Federal Courts*, p. 279 (1985), rather than post-enactment statements regarding legislative intent, particularly when those statements are not even made by the legislators involved." *Id.* at 1379 (Coffey, J., dissenting). *See Western Air Lines v. Board of Equalization of South Dakota*, 107 S.Ct. 1038, 1043 note (1987). Instead of searching post-enactment statements for evidence of legislative *motive*, the majority opinion should have focused on the *text* of the statute, section two of which sets forth the *intent* of the Act:

---

[2] Section 3(A) defines an "ambulatory surgicial treatment center" as "any . . . place . . . devoted primarily to . . . the performance of surgical procedures or any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose." Ill. Rev. Stat., ch. 111½, par. 158-8.3(A). As a result of the Illinois Supreme Court's decision in *Village of Oak Lawn v. Marcowitz*, 86 Ill.2d 406, 427 N.E.2d 36 (1981), the Act and the regulations promulgated thereunder have been applied only to facilities that are primarily devoted to the performance of surgical procedures (including abortions). 841 F.2d at 1363.

[3] The minutes were admitted only for the limited purpose of establishing the Board's state of mind regarding its enforcement procedures. *Id.*

> It is declared to be the public policy that the State has a legitimate interest in assuring that all medical procedures, including abortions, are performed under circumstances that insure maximum safety. Therefore, the purpose of this Act is to provide for the better protection of the public health through the development, establishment, and enforcement of standards (1) for the care of individuals in ambulatory surgical treatment centers, and (2) for the construction, maintenance and operation of ambulatory surgical treatment centers, which, in light of advancing knowledge, will promote safe and adequate treatment of such individuals in ambulatory surgical treatment centers.

Ill. Rev. Stat., ch. 111½, par. 157-8.2. That the Act was designed to protect public health and not to promote a hidden agenda of restricting abortion is evident from an examination of the pertinent legislative history.

The Ambulatory Surgical Treatment Center Act was created by Senate Bill 1051, sponsored by Senator Wooten. Legislative Synopsis and Digest, 1973 Sess., 78th Ill. Gen. Assem. at 508. The primary purpose of the Act "was to regulate and prescribe safeguards for the rapidly developing trend of cost-effective ambulatory surgical treatment medical services." *Ragsdale*, 841 F.2d at 1377 (Coffey, J., dissenting). *See generally*, L. Burns, *Ambulatory Surgery: Developing and Managing Successful Programs* (1984).

At the express request of the Illinois State Medical Society, Senate Bill 1051 was considered together with Senate Bills 1049 and 1050, which were drafted in an attempt to bring the Illinois abortion statutes into compliance with this Court's then-recent decisions in *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973), notwithstanding the sponsor's serious reservations about including Senate Bill 1051 in a package of bills regulating abortion. 78th Ill. Gen. Assem., Senate

Proceedings, June 1, 1973, pp. 42-43, 45.[4] All three bills were drafted by the Illinois State Medical Society, which supports legalized abortion, the Illinois Hospital Association and the Illinois Department of Public Health. 78th Ill. Gen. Assem., Senate Proceedings, May 29, 1973, at 26; House Proceedings, July 1, 1973, at 106.

Senator Wooten explained the purpose of Senate Bill 1051:

> [Senate Bill 1051] has to do with the ambulatory-surgical treatment center, which is a center for the performance of minor surgery that does not require an overnight stay. *This . . . is an attempt to attack the very problem alluded to by Senator Sours, the tremendous expense of a hospital stay.* Such centers are not limited to abortions. They can do all sorts of minor surgery.

Senate Proceedings, May 29, 1973, at 33-34 (emphasis added). Later in the debate, the sponsor stated:

> *While this [Senate Bill 1051] has a relationship to abortion, it actually goes much beyond that. It provides for the establishment and licensing of facilities which can perform minor surgery.* This would be things like tonsillectory, hernias, abortions would be included, facial surgery, plastic surgery and so on. In other words[,] procedures which would not require an overnight stay. And indeed these ambulatory surgical treatment centers are forbidden to keep patients overnight. However, . . . untoward things can occur at any time, and so provision is made in

[4] "That the ASTCA was initially a companion bill to the abortion bills is more of a historical coincidence relished by political opportunists who, in this case, apparently fully utilized it to their advantage. As the minutes of the licensing board reflect, for whatever their worth: 'Without the public interest in abortions, we would not have any of the present legislation.' That is to say that the state legislators and other interested parties who were primarily interested in regulating ambulatory medical services would not have been able to enact the legislation without the statewide and even nationwide interest in the abortion question at the time." 841 F.2d at 1382 (Coffey, J., dissenting).

> here that *doctors who function in such a center must also be licensed to practice in a hospital nearby so that if any complications occur they can quickly move the patient to that place.* Now, I handed out an outline to explain to you how these things would work, definitions, they must get a license, some of these things are left open as to regulations. The Department [of Public Health] would like to take a hand in that. *This is something [that] doctors have been urging us to do for a couple of years now, and ambulatory surgical treatment centers are . . . are in effect out west. The idea is that they can be a great saving to a patient.* One of the big costs in a hospital, if you remember it's kind of like a hotel which has special services. And if you don't need that overnight stay, you can save a great deal of money. So there's a great savings possible for the patient who needs this kind of a one-day surgical treatment. *It does include abortion, and everything would be rather closely regulated and inspected.*

Senate Proceedings, June 1, 1973, at 43 (emphasis added). After Senator Wooten indicated that abortion was simply "one of the procedures that would be possible" to perform in an ambulatory surgical treatment center, Senator Knuppel expressed his support:

> [T]his bill is a good bill. It's not related in any way to abortions. It's sponsored by the Medical Association. There's nothing wrong with ambulatory medical services.

Senate Proceedings, June 1, 1973, at 44.

Some opponents of legalized abortion opposed the legislation, believing that the bills would facilitate the performance of abortions in Illinois. Defending Senate Bill 1051 against Senator Ozinga's accusation that the bill would make abortions easier to obtain in Illinois, Senator Wooten responded that "*the main thrust of this is to try to save some money by getting minor surgical treatment out of the hospital where it is hideously expensive and into a clinic.*" Senate Proceedings, June 1, 1973, at 45 (emphasis added). The Senate approved the bill on a

vote of 30 to 6, one member voting present (Illinois Senate Journal (1973) at 1531), and it was then taken up by the House of Representatives. The House sponsor, Representative Day, spoke in support of the bill:

> Now the last Bill . . . licenses Ambulatory Surgical Treatment Centers . . . . [*T*]*his Bill is not limited to the matter of abortions, but it would include such things as* [*o*]*ral* [*s*]*urgery or very minor operations or stitching in case someone needs a few stitches and it fairly sets up stringent regulations for the licensing of these facilities.* It provides that they must be operated under the medical supervision of a physician and that if surgery is performed by a doctor, it must be by a doctor who can admit a patient to a hospital if complications arise. [*Senate bill 1051*] [*c*]*ontains very strict regulations for the licensing of these Ambulatory Surgical Treatment Centers.*

House Proceedings, July 1, 1973, at 107 (emphasis added).

Immediately before the final vote in the House, Representative B. B. Wolfe spoke in favor of Senate Bills 1049, 1050 and 1051:

> [*A*]*n editorial* [*in the Chicago Sun Times*] . . . *said,* "[*W*]*e urge House Members, many of whom are violently opposed to . . . legislation of abortion to view the measures not as pro-abortion Bills but as public health measures.*"] *That is what they are and they should be approved as such* and I heartily endorse this package because it is the only one in the State of Illinois to carry out quality medicine in this area.

House Proceedings, July 1, 1973, at 110 (emphasis added).[5] The House of Representatives approved Senate

[5] It should be noted that in 1969, Representative Wolfe sponsored House Bill 1407, which, if enacted, would have repealed the former Illinois abortion statutes, which permitted abortion only to preserve the life of the woman, and would have allowed abortion on demand through the twentieth week of pregnancy, and on specified grounds thereafter. House Bill 1407, 76th Ill. Gen. Assem. (1969).

Bill 1051 on a vote of 111 to 14, twenty-four members voting present. Illinois House Journal (1973) at 5034-35.

Review of the legislative debate reveals that supporters of Senate Bills 1049, 1050 and 1051 were at pains to reassure opponents of abortion that the bills would not legalize abortion on demand in Illinois. Notwithstanding these reassurances, several senators and representatives with strong records of opposing abortion refused to support the bill. Senate Proceedings, June 1, 1973, at 45 (remarks of Senator Ozinga); House Proceedings, July 1, 1973, at 108-09 (remarks of Representatives Hudson, R.D. Walsh); Senate Journal (1973) at 1531; House Journal (1973) at 5034-35.

It is apparent from the foregoing that there is no basis in fact for the court of appeals' finding that the Ambulatory Surgical Treatment Center Act was "enacted primarily with abortion clinics in mind . . . ." 841 F.2d at 1369.[6] "[C]ontrary to the majority's mere speculative assertions," Judge Coffey correctly observed in dissent, "the legislative history clearly and unequivocally supports

[6] This is evident not only from the overwhelming support Senate Bill 1051 received from both houses of a legislature deeply divided on the issue of abortion, but also from a comparison of the voting on that bill with the voting on three pre-*Roe* bills which would have relaxed legal restrictions on abortion. In 1969, the Illinois House of Representatives considered and rejected a series of bills that would have substantially broadened the circumstances under which abortions could be performed. House Bills 634, 663 and 1407, two of which would have allowed abortion on demand, were defeated on votes of 103 to 57, 80 to 51 and 91 to 38, respectively. House Journal (1969) at 1805-06, 2802, 3736-37.

Of the scores of representatives who voted on House Bills 634, 663 and 1407 in 1969 and also on Senate Bill 1051 in 1973, all but one of the members voting in favor of the former bills voted in favor of the latter. House Journal (1969) at 1805-06, 2802, 3736-37; House Journal (1973) at 5034-35. It strains credulity to suggest that legislators who voted in favor of abandoning virtually any legal control of abortion prior to *Roe v. Wade* would have voted in favor of the bill creating thhe ASTCA if they had believed that the bill would have restricted access to abortion.

the proposition that the ASTCA was not enacted primarily to regulate abortions, but rather for the regulation of all semi-complicated (minor) surgical procedures performed in the rapidly developing ambulatory surgical treatment centers." *Id.* at 1381 (Coffey, J., dissenting). The legislative history of the ASTCA thus provides no basis for impugning the "motives" of the Illinois General Assembly.

II. THE ILLINOIS HEALTH FACILITIES PLANNING ACT WAS ENACTED IN 1974 TO CONTROL THE COST OF HEALTH CARE FACILITIES AND NOT WITH ANY PRIMARY PURPOSE OF REGULATING ABORTION.

The court of appeals also held that the "certificate of need" proceeding requirement of the Illinois Health Facilities Planning Act (Ill. Rev. Stat., ch. 111½, par. 1151 *et seq.* (1987)) (IHFPA), could not constitutionally be applied to ambulatory surgical treatment centers that perform abortions. *Id.* at 1374-75. The court found that the State's "interest in preventing wasteful duplication of resources" is not compelling, and that "[w]here the exercise of constitutional rights is concerned, the government may play no role in determining whether outlets for their exercise are 'needed'" *Id.* Apparently, the court was led to use strict scrutiny because of its belief that the IHFPA was "part of a 'tripartite' legislative scheme to limit the availability of abortions." *Id.* at 1381 (Coffey, J., dissenting). Again, the legislative history refutes this interpretation.

The IHFPA was passed by the General Assembly on June 28, 1974, and signed into law by the Governor on August 27, 1974, more than one year *after* the ASTCA was enacted. Section 2 identifies the legislative purposes of the Act:

> [T]o establish a procedure designed to reverse the trends of increasing costs of health care resulting from unnecessary construction or modification of health care facilities. Such procedure [requiring a certificate of need] shall represent an attempt by the State of Illinois to improve the financial ability of the public to obtain necessary health services, and to establish an orderly and comprehensive health care delivery system which will guarantee the availability of quality health care to the general public.

Ill. Rev. Stat., ch. 111½, par. 1152. The Act enjoyed the support of the Illinois State Medical Society, the Illinois Hospital Association and the Nursing Home Association.[7] By its terms, the Act applies to all ambulatory surgical treatment centers, but not to "facilities operated as a part of the practice of a physician . . . ." Par. 1153. Abortion clinics, because they are ambulatory surgical treatment centers, fall within the scope of the IHFPA. But there is not a scintilla of evidence that the Act was intended to regulate abortion clinics merely because they perform abortions—abortion is not mentioned in the Act or in the legislative debates thereon. *See* Senate Proceedings: June 5, 1974, at 20-29, June 6, 1974, at 38-45, 233-39; House Proceedings: June 27, 1974, at 241-57, June 28, 1974, at 217-30.

The IHFPA was created by Senate Bill 1609. Its purpose was explained by Senator Knuepfer, one of the sponsors:

> [Senate Bill 1609] addresses itself to a problem that we have in Illinois, *and that problem is essentially a surplus in hospital facilities.* We all pay for that surplus in hospital facilities and one of the motivating forces behind the bill has been those insurance companies as well, who take our dollars as third party payers to pay the hospital, and *it [Senate Bill 1609] sets up a mechanism for determining whether or not this [dramatic] expansion in hospital facilities can continue.*

Senate Proceedings, June 6, 1974, at 234 (emphasis added). Representative Kempiners echoed this thought in his remarks:

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[7] 78th Ill. Gen. Assem., Senate Proceedings, June 6, 1974, at 233.

> We're all familiar with the problems that the people of Illinois have today in paying for hospital care. Part of that problem is unused hospital beds. . . . Senate Bill 1609 . . . will provide a means *for proper planning with local input and decision making to cut down on empty hospital facilities*, nursing home facilities, sheltered care . . . facilities *and* . . . *ambulatory surgical facilities.*

House Proceedings, June 28, 1974, at 217-18 (emphasis added).

Notwithstanding this legislative history, the Seventh Circuit struck down the IHFPA, in part, because the court construed the motive of the Illinois legislators to be the suppression of abortion per se. Based upon the text of the acts and their legislative history, Judge Coffey correctly concluded, to the contrary, that "there is no proof in this record that either the ASTCA or the IHFPA [was] enacted primarily to regulate abortions; rather, these laws were adopted to regulate the delivery of medical services to its citizens and to attempt to prevent and control the further unnecessary overexpansion of Illinois' medical facilities." 841 F.2d at 1382.[8]

III. THE AMBULATORY SURGICAL TREATMENT CENTER ACT AND THE REGULATIONS ADOPTED BY THE DEPARTMENT OF PUBLIC HEALTH WERE SUBSTANTIALLY AMENDED IN 1979 IN DIRECT RESPONSE TO A *CHICAGO SUN-TIMES* AND BETTER GOVERNMENT ASSOCIATION INVESTIGATION OF CHICAGO ABORTION CLINICS IN 1978.

The Ambulatory Surgical Treatment Center Act was first enacted in 1973 to regulate all outpatient surgical facilities. In 1978, however, the attention of the public

[8] At least thirty-six States impose certificate-of-need requirements. Bovbjerb, *Problems and Prospects for Health Planning: The Importance of Incentives, Standards, and Procedures in Certificate of Need*, 1978 Utah L. Rev. 83. The economic effects of the certificate of need system are discussed in *Symposium: Certificate of Need Laws in Health Planning*. 1978 Utah L. Rev. 1.

and the Illinois legislature was drawn to Chicago abortion clinics by a series of articles in the *Chicago Sun-Times*, entitled "The Abortion Profiteers," which was based on a five-month, undercover investigation undertaken by the *Chicago Sun-Times* and the Better Government Association, a private watchdog group. This series was cited by Justice Powell in his plurality opinion in *Planned Paernthood Ass'n of Kansas City, Missouri, Inc. v. Ashcroft*, 462 U.S. 476, 488 n.12 (1983).[9] Specifically referring to "The Abortion Profiteers," which "disclosed widespread questionable practices in abortion clinics in Chicago," Justice Powell noted that "not all abortion clinics, particularly inadequately regulated clinics, conform to ethical or generally accepted medical standards." *Id.*

The *Sun-Times* and the Better Government Association made the following findings:

> (1) Twelve women suffered fatal infections or bled to death after undergoing abortion procedures in state-regulated clinics;
>
> (2) Many women, because of unsterile conditions and haphazard clinic care, suffered debilitating cramps, massive infections and such severe internal damage that all of their reproductive organs had to be removed;
>
> (3) Dozens of abortions were performed on women who were not pregnant;
>
> (4) Abortions were illegally performed on women who were more than 12 weeks pregnant;
>
> (5) Abortions were performed by incompetent or unqualified physicians;
>
> (6) Abortions were performed without anesthesia or before anestnetics could take effect;
>
> (7) Patients were forced to leave the recovery room while they were still in pain because of severe overcrowding;

[9] *Amici Curiae* have lodged ten copies of this serics of articles with the Clerk of the Court.

(8) Unqualified personnel filled syringes and gave injections;

(9) Aides were directed to falsify records of patients' pre-operative and post-operative vital signs; [10]

(10) Clinics failed to order critical post-operative pathology reports, ignored the results or mixed up the specimens;[11]

(11) Clinics did not have a registered nurse on staff at all times the facility was open, as required by law;

(12) Clinics were not properly regulated by the Department of Public Health, which lacked adequate administrative procedures to investigate or close dangerous clinics;

(13) Unscrupulous sales techniques were used to pressure women into having abortions;

(14 Kickbacks were paid for abortion referrals;

(15) Women received incompetent counseling by untrained staff.

As a direct result of the *Sun-Times* series, the Subcommittee on Health of the Human Resources Committee of the Illinois House of Representatives conducted public hearings and recommended needed legislation. The Subcommittee, which heard testimony from investigators, state officials, medical experts, clinic operators and representatives from referral services, issued its report on December 13, 1978. "State Regulation Of Abortion Clinics," Report to the Human Resources Committee,

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[10] "According to medical experts consulted by The Sun-Times, it is essential to measure both pulse and blood pressure before and after abortions: before, to be sure the patient can tolerate the procedure and the anesthesia; after, to detect excess bleeding, shock or other life-threatening complications." "The Abortion Profiteers," *Chicago Sun-Times*, November 16, 1978, p. 19.

[11] Accurate pathology reports are essential because they indicate whether the patient was in fact pregnant, whether the abortion was incomplete or whether the patient may be suffering from a life-threatening ectopic pregnancy. "The Abortion Profiteers," *Chicago Sun-Times*, November 19, 1978, p. 25.

Subcommittee on Health, 80th Ill. Gen. Assem. (1978) (hereinafter 1978 Report).[12]

The report, which relied heavily on the *Sun-Times* investigation for its conclusions, urged legislative and administrative action that would generally upgrade monitoring and enforcement. *See* 1978 Report, Summary of Recommendations.[13] Virtually all of their recommendations were incorporated into amendments to the Ambulatory Surgicial Treatment Center Act and the regulations promulgated thereunder. *See* House Bill 438, Senate Bill 676, 81st Ill. Gen. Assem. (1979); 3 Ill. Reg. Vol. 10, pp. 43-54 (1979); 3 Ill. Reg. Vol. 30, pp. 371-89 (1979); 6 Ill. Reg. 6220 *et seq.* (1982); 6 Ill. Reg. 13337 *et seq.* (1982).[14]

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[12] *Amici Curiae* have lodged ten copies of the Subcommittee's Report with the Clerk of the Court.

[13] That the Subcommittee was not motivated by an anti-abortion animus is evident from its marked hostility to the legislature's efforts to regulate abortion in the wake of *Roe v. Wade*, 410 U.S. 113 (1973), and its final recommendation that abortion services should be made available "in all areas of the State." *See* Subcommittee on Health Report, Introduction and pp. 16-17.

[14] For example, the court of appeals found that minimum size requirements for recovery rooms were not "medically necessary" and had "no medical justification whatsoever." (841 F.2d at 1368, 1373), but the *Sun-Times* and the House Subcommittee found that recovery rooms were not large enough to accommodate all patients, thereby forcing some to leave clinics while they were still in pain. Koshner & Zekman, "Jury subpenas [sic] records of abortion clinic," *Chicago Sun-Times*, November 12, 1978, at 5-6; 1978 Report at 10.

Likewise, the court of appeals held that "the State may not require separate licensure of facilities primarily devoted to performing abortions." 841 F.2d at 1371. But the House Subcommittee recommended that inspections pursuant to the ASTC licensing act should be stepped-up, that reports submitted by physicians pursuant to the licensing act should be more carefully monitored, that the Department of Public Health should be given greater authority to close clinics whose licenses have been suspended, that licensure fees should be imposed to "offset some of the costs of the . . . regulatory program" and that penalties should be "stiffen[ed]" for

The following spring, 1979, amendatory bills were sponsored in the General Assembly. The principal bill (House Bill 438) was sponsored by Representatives Cullerton, Chapman and Kelly, the first two of whom support legalized abortion.[18] Dr. Nina Adams, President of the "People's Alliance for Reproductive Choice," and Sherry S. Walker, administrator of the Concord Medical Center, an abortion clinic, appeared before the House Committee on Human Resources in support of House Bill 438. Bruce Simon, a representative of Planned Parenthood of Chicago, appeared before the Senate Committee on Public Health, Welfare & Corrections in support of the bill.

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operating a clinic without a license. The Subcommittee recommended that licensure standards for abortion clinics should generally be as strict as those for nursing homes. 1978 Report at 2-6. The *Sun-Times* found that Dr. Arnold Bickman, one of the subjects of the exposé, was operating three clinics in different States—"all without state licenses." Zekman & Warrick, "Meet the Profiteers," *Chicago Sun-Times*, November 13, 1978, at 1.

The court declared "invalid" the regulation requiring the same doctor who performs the abortion to perform a pregnancy test. 841 F.2d at 1372 (citing 77 Ill. Admin. Code, sec. 205.730(a)(2)). But the *Sun-Times* found that abortions were performed on women who were not pregnant (Zekman & Warrick, "The Abortion Profiteers," *Chicago Sun-Times*, November 12, 1978, at 1), and the Subcommittee recommended that the attending physician inform the patient of the test results. 1978 Report at 9.

Neither the *Sun-Times* investigative series nor the Report of the House Subcommittee on Health was ever mentioned in the majority opinion, despite the fact that both the series and the Report were submitted to the court.

[18] In 1969, Representative Chapman co-sponsored House Bill 634, which would have repealed the substantive provisions of the principal Illinois abortion statute and would have allowed aborton on demand throughout pregnancy. House Bill 634, 76th Ill. Gen. Assem. (1969). Representative Cullerton joined a brief in *Webster v. Reproductive Health Services, Inc.*, 109 S.Ct. 3040 (1989), urging this Court *not* to overrule *Roe v. Wade*. See Brief Of *Amici Curiae* On Behalf Of 608 State Legislators From 32 States, at 4a.

The bill, as enacted, imposes licensing fees; confers upon the Director of the Department of Public Health discretionary authority to deny issuance of a license to an applicant who has been convicted of a felony or two or more misdemeanors involving moral turpitude, or whose moral character is not reputable, or whose licensure status or record in another State indicates that granting a license would be detrimental to the interests of the public; requires detailed statements of ownership and financial statements; mandates quarterly inspections and makes facilities subject to inspection without prior notice; authorizes the Department to order the immediate closure of any facility which poses an imminent and serious menace to the health or safety of its patients or which is run by a person who previously has been convicted of operating an unlicensed facility; enhances the penalties for operating an unlicensed facility or one not in compliance with applicable statutes and regulations.

A floor amendment to House Bill 438, authorizing the Department of Public Health to order the immediate closure of an unsafe facility, was offered by Representative Pullen, who explained the necessity of conferring this power on the Department:

> [W]hen we had the Committee hearing on this Bill, . . . several Members . . . felt there was a problem in the provisions concerning the possible closing down of an abortion clinic. And the problem that they saw was that it gave the clinic 24 hours notice before it could be closed down. . . . And we certainly felt . . . that it was much more appropriate to follow this procedure [immediate closure followed by an administrative hearing] with respect to abortion facilities than to give a facility 24 hours notice before it is closed down. As was pointed out by witnesses, a facility would have 24 hours in which to clean up its act, face its hearing, continue its license and then go back to the practices that caused the closure to begin with. *So we felt that because of the dangers to human life presented in these facilities, which were exposed very shockingly a few months ago by the*

> *Sun Times, an immediate shut down would be much more in order.* So this Amendment proposes that there would be an immediate . . . that there could be an immediate shut-down by the inspector, then the facility would have 24 hours notice of that action and the procedures for hearing are retained in the Bill so the facility would still be able to appeal.

81st Ill. Gen. Assem., House Proceedings March 27, 1979, at 5-6 (emphasis added). Representative Cullerton, the bill's sponsor, supported the proposed amendment:

> It was disclosed during the Committee hearing that the standard by which an Ambulatory Surgical Treatment Center could be closed down was that when the continued operation of such facility constitutes an imminent and serious menace to the health or safety of the patient, and I feel that when this situation exists there is no need to allow the licensee 24 hours to continue his operation.

Id. at 6.

On third reading, Representative Cullerton spoke at length regarding the need to strengthen the Ambulatory Surgical Treatment Center Act to curb the abuses discovered in the *Sun-Times* articles:

> [L]ast year the Chicago Sun Times and the [Better] Government Association disclosed the atrocities that were being performed in the abortion clinics on Michigan Avenue in Chicago. A special subcommittee of the House, made many recommendations to respond to the investigations and the findings of that exposé. The next 4 Bills which we are to consider [House Bills 437, 438, 439 and 440] are the implementations of those recommendations. *Whether one is an opponent of abortion or not, there must be universal support for the improved regulation of these facilities and the enforcement of existing laws so that the [risk] of death and injury can be lessened. We cannot tolerate a situation that continues to allow profiteers to victimize women seeking abortions. This package of Legislation is concerned solely with improved regulation of the facilities operating as abor-*

> *tion clinics in Illinois. It is not designed to limit [or] restrict [a woman] from getting an abortion, nor is it intended to make it easier for women to obtain abortions. The objective is to insure [that] these facilities are operated in a safe and healthy manner. The sooner we do that, the sooner we will know that women will not experience any more tragedies of the type reported last fall.*

House Proceedings, April 10, 1979, at 52 (emphasis added). Speaking again in support of this legislation, Representative Cullerton said:

> *We're trying to eliminate the shoddy practices that were being performed in these clinics.* The only time that a clinic can be closed down immediately is if the health of the patient is at stake . . . if there are serious conditions which could affect the life [or] the health of the woman in these clinics.

Id. at 54 (emphasis added).

The House of Representatives approved the bill on a vote of 161 to 1. *Id.* at 55.

Speaking in support of the bill, Senator Carroll stated:

> This . . . is part of the package of abortion reform legislation to upgrade the Department of Public Health's ability to license surgical treatment centers. This bill would provide that the department can assess the applicant to determine if there were any criminal records involving the people who will be operating these facilities. It will require that they have physicians on its staff and that these physicians be outlined in name to a person who would come in to these surgical treatment centers. It would prohibit expenditures of public funds for patients which have not filed the necessary financial disclosures statements and require an annual licensing. *Basically this legislation is necessary to allow the department to better regulate these treatment centers and deny licenses as we have seen in the newspaper articles, deny licenses to those types of facilities that I*

> *believe every member of the Senate would say should not be allowed to exist in the State of Illinois.*

Senate Proceedings, June 20, 1979, at 64 (emphasis added). The Senate approved House Bill 438, as amended, on a vote of 56 to 0, one member voting present. *Id.* The bill was returned to the House of Representatives, which concurred in the Senate's amendment on a vote of 137 to 0. House Proceedings, June 24, 1979, p. 33.

Senate Bill 676, which also amended the Ambulatory Surgical Treatment Center Act, was introduced in the same legislative session as House Bill 438. The bill, as enacted, requires a corporation operating an ASTC "devoted primarily to providing facilities for abortion" to have a licensed physician who is "actively engaged in the practice of medicine at the Center, on the board of directors as a condition of licensure." The purpose of the bill, as explained by its sponsor, Senator Adeline Geo-Karis, was "to protect people who have to use these ambulatory treatment pregnancy centers." Ill. Gen. Assem., Senate Proceedings, May 17, 1979, at 89. The bill provides "a safeguard for the women who are going to go through these clinics" and is intended to "avoid a lot of vicissitude[s] that have happened in some of these abortion centers." *Id.* at 90. Senator Schaffer voiced his support of the bill:

> We've seen over the years, in these type [of] clinics . . . that the ownership changes very quickly and when the department finds something wrong and they move against the individuals there usually is not a medical practitioner involved. There's usually someone who is profit motivated . . . to operate this place. We get the goods on them. We shut them down and they close the door of Acme Clinic and the next day it's the Uptown Clinic. There are a different set of names with the same medical personnel and the same procedures and we go right back into court and we fight the battle all over again. I don't think it's inappropriate to request and to require that

> one person who could effectively be held responsible for the medical practices in this type of clinic to be involved in the incorporation. I think it's a reasonable proposal and I think it will help us stamp out some of the abuses which we are all so acutely aware of.

Id. at 90-91. The Senate approved Senate Bill 676 on a vote of 46 to 1. *Id.* at 91.

In the House, Representative Leinenweber explained that "Senate Bill 676 was introduced apparently in part in response to the *Sun-Times* series on abortion clinics." House Proceedings, June 18, 1979, at 16. The bill was intended to provide accountability by requiring a physician to serve on the board of directors of an incorportaed ambulatory surgical treatment center whose principal business is performing abortions. *Id.* at 18-19, 24-25 (remarks of Rep. Leinenweber). The House of Representatives approved Senate Bill 676, as amended, on a vote of 148 to 0, two members voting present. House Proceedings, June 20, 1979, at 127. The bill was returned to the Senate which concurred in the amendment on a vote of 53 to 0. Senate Proceedings, June 23, 1979, at 138.

Even before the Illinois General Assembly considered these bills, the Department of Public Health took prompt action to remedy the more serious abuses uncovered by the *Sun-Times* series. On February 23, 1979, the Department invoked its emergency rulemaking authority because "[a]ny delay . . . will permit conditions to continue that may be detrimental to the public health and safety." 3 Ill. Reg. Vol. 10, p. 43 (1979). The Department's notice specifically referred to "[r]ecent investigations by governmental and private agencies [that] have discovered improprieties in several Ambulatory Surgical Treatment Centers." *Id.* The rules were promulgated "to require these centers to use the services of specially trained medical personnel and to follow a specific procedure in evaluating qualifications of staff as well as ongoing evaluation

of care provided." *Id.* The Department also imposed "[a]dditional requirements for the qualifications of counselors and the quality of counseling" and "new requirements for laboratory examination of tissues removed during the performance of an abortion." *Id.* With minor changes, these rules were made permanent on July 23, 1979. 3 Ill. Reg. Vol. 30, pp. 371-89 (1979).

The majority opinion held that "the State may not require separate licensure of facilities primarily devoted to performing abortions," (841 F.2d at 1371), notwithstanding compelling evidence that regulation of these facilities is *essential* to protect the health, indeed the very lives, of women undergoing abortions. The *amici curiae* fully agree with Judge Coffey that "individual states have the obligation, the duty, and the power to license facilities where semi-complex (minor) surgical procedures, including first-trimester abortions, are performed as a valid exercise of a state's interest in protecting health and ensuring maximum safety for the patients." *Id.* at 1398 (Coffey, J., dissenting). The legislative history indicates that this was the essential purpose of the 1979 amendments to the ASTCA.

IV. IN STRIKING DOWN THE AMBULATORY TREATMENT CENTER ACT AND THE REGULATIONS ADOPTED THEREUNDER, THE COURT OF APPEALS RELIED UPON THE "LEGISLATIVE MOTIVE" DOCTRINE OF *THORNBURGH v. AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS*, WHICH THIS COURT SHOULD EXPRESSLY ABANDON.

In invalidating the ASTCA, the court of appeals looked beyond both the statute itself and the relevant legislative history, and inquired into the legislature's motive. The court opined that the ASTCA "was enacted primarily with abortion clinics in mind and only applied to outpatient surgical clinics generally to save the statute from unconstitutionality." *Id.* at 1369. This attempt to reach beyond the accepted tools of statutory analysis—the plain

language of the statute and the legislative history of the Act—and invalidate otherwise constitutional legislation based on the alleged motivation of the legislators who enacted the statute, is contrary to well-settled rules of constitutional law.

The court's search for legislative motive strays from the "familiar principle of constitutional law that this Court will not strike down an otherwise constitutional statute on the basis of an alleged illicit motive." *United States v. O'Brien*, 391 U.S. 367, 383 (1967). *Accord McCray v. United States*, 195 U.S. 27 (1904). Chief Justice Marshall first enunciated this principle in the landmark decision, *Fletcher v. Peck*, 10 U.S. (6 Cranch) 87 (1810). In setting forth the rule, the Chief Justice first explained the practical impossibility of an inquiry into motive:

> If the principle be conceded, that an act of the supreme sovereign power might be declared null by a court, in consequence of the means which procured it, still would there be much difficulty in saying to what extent those means might be applied to produce this effect. Must it be by direct corruption, or would interest or undue influence of any kind be sufficient? Must the vitiating cause operate on a majority, or on what number of its members? Would the act be null, whatever might be the wish of the nation, or would its obligation or nullity depend upon the public sentiment?

Id. at 130. The Chief Justice then articulated the rule against such an inquiry:

> [Inquiry into the] impure motives [of the legislature] . . . is a question which the court would approach with much circumspection. It may well be doubted how far the validity of a law depends upon the motives of its framers. . . .
>
> If the majority of the legislature be corrupted, it may well be doubted, whether it be within the province of the judiciary to control their conduct, and if

> less than a majority act from impure motives, the principle by which judicial interference would be regulated, is not clearly discerned.

Id.

In *McCray v. United States*, the Court again stressed this principle:

> The decisions of this court from the beginning lend no support to the assumption that the judiciary may restrain the exercise of lawful power on the assumption that a wrongful purpose or motive has caused the power to be exerted. As we have previously said, from the beginning no case can be found announcing such a doctrine, and on the contrary the doctrine of a number of cases is inconsistent with its existence.

195 U.S. at 56.[16]

Chief Justice Warren's opinion in *United States v. O'Brien* reiterated the impropriety of inquiry into legislative motive. The Chief Justice elaborated on the impossibility of determining "the motive" of the legislature, first addressed in *Fletcher v. Peck*:

> Inquiries into congressional motives or purposes are a hazardous matter. When the issue is simply the interpretation of legislation, the Court will look to statements by legislators for guidance as to the purpose of the legislature[], because the benefit to sound decision-making in this circumstance is thought sufficient to risk the possibility of misreading Congress' purpose. It is entirely a different matter when we are asked to void a statute that is, under well-

[16] *See also Brooklyn Union Gas Co. v. Standard Oil Co.*, 391 U.S. 366, 383 (1968); *Daniel v. Family Ins. Co.*, 336 U.S. 220, 223-25 (1948); *Arizona v. California*, 283 U.S. 423, 454 (1930); *Smith v. Kansas City Title & Trust Co.*, 255 U.S. 180, 210 (1921); *Hamilton v. Kentucky Distilleries Co.*, 251 U.S. 146, 161 (1919); *United States v. Doremus*, 249 U.S. 86, 93 (1919); *Dakota Central Tel. Co. v. South Dakota*, 250 U.S. 163, 187 (1918); *Wilson v. New*, 243 U.S. 332, 358-59 (1917); *Weber v. Fried*, 239 U.S. 325, 329-30 (1915); *United States v. Des Moines Nav. & Ry. Co.*, 142 U.S. 510, 544-45 (1892); *Doyle v. Continental Ins. Co.*, 94 U.S. 535, 541 (1877); *Aldridge v. Williams*, 44 U.S. (3 Howard) 15, 23 (1845).

> settled criteria, constitutional on its face, on the basis of what fewer than a handful of Congressmen said about it. What motivates one legislator to make a speech about a statute is not necessarily what motivates scores of others to enact it, and the stakes are sufficiently high for us to eschew guesswork.

391 U.S. at 383-384.[17] This Court and individual justices have reaffirmed this principle more recently. *See Palmer v. Thompson*, 403 U.S. 217 (1971); *City of Renton v. Playtime Theatres, Inc.*, 475 U.S. 41 (1986); *Boos v. Barry*, 108 S.Ct. 1157, 1171 (1988) (Brennan, J., concurring).[18]

As a matter of constitutional principle, this Court uniformly refuses to probe the motivation of the legislature where, as here, the challenged statute is otherwise constitutional. Generally, the Court has been unwilling to engage in such an inquiry except in Equal Protection Clause cases and cases under the Establishment Clause, and even there, inquiry into legislative motive has met with strong opposition.

In Equal Protection Clause cases, discriminatory intent will be considered if, and only if, the challenged statute or policy has a disproportionate discriminatory effect. *Washington v. Davis*, 426 U.S. 229, 239 (1976). *Accord,*

[17] Justice Scalia has also voiced his disapproval of searching the motives of the legislature. In *Edwards v. Aguillard*, 482 U.S. 578 (1987), he wrote that "determining the subjective intent of legislators is a perilous enterprise," and that "[t]o look for *the sole purpose* of even a single legislator is probably to look for something that does not exist." *Id.* at 637 (emphasis in original).

[18] The lower federal courts have also consistently refused to inquire into the legislative motive behind an otherwise constitutional statute. *See, e.g., Fraternal Order of Police Hobart Lodge No. 121, Inc. v. City of Hobart*, 864 F.2d 551 (7th Cir. 1988); *Torres v. Delgado*, 510 F.2d 1182 (1st Cir. 1975); *Wall Distributors, Inc. v. City of Newport News*, 782 F.2d 1165 (4th Cir. 1986); *Felix v. Young*, 536 F.2d 1126 (6th Cir. 1976); *Wilderness Society v. Morton*, 479 F.2d 842 (D.C. Cir. 1973); *Sipes v. United States*, 321 F.2d 174 (8th Cir. 1963); *United States v. Ross*, 458 F.2d 1144 (11th Cir. 1972).

e.g., *Arlington Heights v. Metropolitan Housing Development Corp.*, 429 U.S. 252, 264-65 (1977); *Personnel Administrator v. Feeney*, 442 U.S. 256, 272-274 (1979) (gender discrimination); *Hunter v. Underwood*, 471 U.S. 222, 227-28 (1985). The finding of a disproportionate effect serves as the necessary pry to open the door of inquiry into legislative motive.

In Establishment Clause cases, this Court applies the three-prong test enunciated in *Lemon v. Kurtzman*, 403 U.S. 602, 612-13 (1971), the first prong of which requires inquiry into the legislative motive. ("It is clear, first of all, that regardless of what 'legislative purpose' may mean in other contexts, for the purpose of the *Lemon* test it means 'actual' motives of those responsible for the challenged action." *Edwards v. Aguillard*, 482 U.S. 578, 613 (1987) (Scalia, J., dissenting). The inappropriateness of a test requiring inquiry into the minds and motives of lawmakers has generated considerable criticism from members of this Court, including calls for its abandonment. *See, e.g., County of Alleghany v. American Civil Liberties Union*, 109 S.Ct. 3086 (1989) (Kennedy, J., dissenting) ("Substantial revision of our Establishment Clause doctrine may be in order; but it is unnecessary to undertake that task today," *Id.* at 3134; *Edwards v. Aguillard*, 482 U.S. 578, 636-640 (1987) (Scalia, J., dissenting); *Wallace v. Jaffree*, 472 U.S. 38, 108-113 (1985) (Rehnquist, J., dissenting); *Epperson v. Arkansas*, 393 U.S. 97, 113 (1968) (Black, J., concurring).

As the Equal Protection Clause and Establishment Clause cases demonstrate, the Court's willingness to engage in an analysis of legislative motive—in these two narrow areas where such inquiry has been entertained—is waning. Inquiry into legislative motive in other areas of the law represents an unwarranted and substantial departure from long-settled constitutional principles.

The court of appeal's reliance on legislation motive was implicitly based on *Thornburgh v. American College of*

Obstetricians and Gynecologists, 476 U.S. 747 (1986). There, the majority invalidated Pennsylvania's Abortion Control Act based on an inquiry into legislative motive. *Id.* at 751 *passim*. As Justice White observed in his dissent, however, *Thornburgh* marked a radical departure from accepted constitutional principles.

> The majority's opinion evinces no deference toward the State's legitimate policy. Rather, the majority makes it clear from the outset that it simply disapproves of any attempt by Pennsylvania to legislate in this area. The history of the state legislature's decade-long effort to pass a constitutional abortion statute is recounted as if it were evidence of some sinister conspiracy. [Citation]. In fact, of course, the legislature's past failure to predict the evolution of the right first recognized in *Roe v. Wade* is understandable and is in itself no ground for condemnation. Moreover, the legislature's willingness to pursue permissible policies through means that go to the limits allowed by existing precedents is no sign of *mens rea*. The majority, however, seems to find it necessary to respond by changing the rules to invalidate what before would have been permissible.

Id. at 798 (White, J., dissenting).

That the peculiar legislative motive analysis engaged in *Thornburgh* has precipitated an unprecedented change in principles of constitutional analysis in the context of abortion is evidenced by the number of lower federal courts echoing *Thornburgh's* motive inquiry. For example, in its findings of fact upon which it relied in invalidating Minnesota's parental notice law, the district court found that "a desire to deter and dissuade minors from choosing to terminate their pregnancies also motivated the legislature." *Hodgson v. Minnesota*, 648 F. Supp. 756, 766 (D. Minn. 1986), *rev'd on other grounds*, 853 F.2d 1452 (8th Cir. 1988). Similarly, Judge Williams found support in *Thornburgh* for his determination that the abortion regulation at issue was "*actually* undertaken to discourage constitutionally privileged induced abortions." *Margaret S. v. Edwards*, 794 F.2d 994, 1002

(5th Cir. 1986) (Williams, J., concurring) (emphasis added).

The legislative motive analysis in *Thornburgh* is inconsistent with the well-settled principle that legislative motive ought not be considered when the statute is otherwise constitutional, and is consistent only with "an entirely different principle: that in cases involving abortion, a permissible reading of a statute is to be avoided at all costs." 476 U.S. at 812 (White, J., dissenting). The legislative motive analysis thoroughly infected the court of appeals' decision. It caused the court not to focus on the effect of Illinois' regulatory scheme, but to speculate on the motivations of unnamed legislators; it caused the court to ignore the actual reasons behind specific statutes and regulations and to focus instead on the motivations behind a "tripartite scheme;" it caused the court to ignore entirely the critical public health problems that surfaced in 1978, and to focus on the minutes of unrelated meetings that occurred in 1974. The court's opinion thus stands as a revealing example of why the legislative motive analysis of *Thornburgh* should be expressly abandoned.

CONCLUSION

The judgment of the United States Court of Appeals for the Seventh Circuit should be reversed.

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BRIEF

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No. 88-790

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

BERNARD J. TURNOCK, M.D., *et al.*,
Appellants,

v.

RICHARD M. RAGSDALE, M.D., *et al.*,
Appellees.

On Appeal from the United States Court of Appeals for the Seventh Circuit

BRIEF OF FEMINISTS FOR LIFE OF AMERICA AND AMERICAN ASSOCIATION OF PROLIFE OBSTETRICIANS AND GYNECOLOGISTS AS AMICI CURIAE IN SUPPORT OF APPELLANTS

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF THE AMICI	1
SUMMARY OF ARGUMENT	2
ARGUMENT	3
I. THE STATUTES AND REGULATIONS ADOPTED BY ILLINOIS ARE SUPPORTED BY A CLEAR AND COMPELLING INTEREST IN REDUCING MATERNAL MORTALITY AND MORBIDITY	3
A. The Opinions Below Have Rendered Impossible Any Effective Regulation of Abortion Clinics In Illinois, With Tragic Consequences	3
B. The Regulatory Scheme is Supported by Substantial Evidence, from Illinois and Other Jurisdictions, that Maternal Mortality and Morbidity Persist, Despite the Legality of Abortion, Especially Where Regulation is Lax	5
C. Licensing of Abortion Clinics is the Most Fundamental and Effective Means of Safety Regulation, and the Majority Below Clearly Erred in Holding that the State Could Not Require Separate Regulation of Clinics	12
D. Both the General and Abortion-Specific Provisions Challenged by Respondents Are Justified by Important Interests in Preventing Maternal Mortality and Morbidity	14
1. The Abortion-Specific Regulations Are Valid	14
2. The General ASTC Regulations Are Validly Applied to Abortion Clinics	17

TABLE OF CONTENTS—Continued

Page

II. ILLINOIS' STATUTORY AND REGULATORY SCHEME FOR REGULATING THE PERFORMANCE OF ABORTIONS IN NON-HOSPITAL SETTINGS IS A VALID EXERCISE OF STATE AUTHORITY TO PROTECT MATERNAL HEALTH 19

A. Whether the State Interest in Maternal Health is Labelled "Compelling" or "Important," It Is Clearly Adequate to Support the Regulations at Issue Here 19

B. The Court of Appeals Followed An Erroneous Standard of "Medical Necessity" in Invalidating the Illinois Statute and Regulations as They Apply to First and Early Second Trimester Abortions 22

1. By Requiring that Abortion Regulations Be Justified as "Medically Necessary," and by Holding that Abortion Cannot be Regulated on the Same Basis as Other Surgical Procedures, the Majority Misconstrued the Pre-*Webster* Standard of Review 22

2. Abortion Regulation Need Not Be Narrowly Tailored to That Which Is Necessary to Regulate a Highly-Skilled Practitioner 25

3. The Court of Appeals Found An Undue Burden on Women's Rights Where None Exists, and Ignored the Genuine Burdens Upon Women Which These Regulations Address 26

C. The Trimester Framework of *Roe v. Wade* Should Be Overturned 29

CONCLUSION 30

TABLE OF AUTHORITIES

CASES

Page

Akron v. Akron Center for Reproductive Health, 462 U.S. 416 (1983) 16, 21
Charles v. Carey, 627 F.2d 772 (7th Cir. 1980) 22, 23
Connecticut v. Menillo, 423 U.S. 9 (1975) 14, 20
Friendship Medical Center Ltd. v. Chicago Board of Health, 505 F.2d 1141 (7th Cir. 1974); *cert. denied*, 420 U.S. 997 (1975) ..... *passim*
Harris v. McRae, 448 U.S. 297 (1980) 21
Hedd Surgi-Center, Inc. v. Turnock, 711 F. Supp. 439 (N.D. Ill. 1989) 18
Hodgson v. Minnesota, 3-81-Civil-538 (D. Minn. 1986) 8
Planned Parenthood Association v. Ashcroft, 462 U.S. 476 (1983) ..... *passim*
Planned Parenthood of Missouri v. Danforth, 428 U.S. 52 (1976) 15, 16
Ragsdale v. Turnock, 841 F.2d 1358 (7th Cir. 1988), *juris. postponed*, 109 S.Ct. 3239 (1989) ..... *passim*
Roe v. Wade, 410 U.S. 113 (1973) ..... *passim*
Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747 (1986) 3, 20
Village of Oak Lawn v. Marcowitz, 86 Ill.2d 406, 427 N.E.2d 36 (1981) 13
Webster v. Reproductive Health Services, 109 S.Ct. 3040 (1989) 3, 20, 21, 30
Whalen v. Roe, 429 U.S. 589 (1977) 18

STATUTES

Ambulatory Surgical Treatment Center Act, Ill. Rev. Stat. ch. 111 1/2, ¶¶ 157-8.1, *et seq.* ..... *passim*
Medical Practice Act, Ill. Rev. Stat. ch. 111, ¶¶ 4400-22 13
Senate Bill No. 804, General Assembly of Tennessee, effective June 2, 1989 14

REGULATIONS

Ambulatory Surgical Treatment Center Licensing Requirements, 77 Ill. Adm. Code, ch. 1, § 205, subchapter 6 ..... *passim*

TABLE OF AUTHORITIES—Continued

OTHER AUTHORITIES

	Page
Abortion Surveillance 1985, U.S. Dep't for Health and Human Services, Centers for Disease Control	9
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Barnes, *Ambulatory Maternal Health Care and Family Planning Services* (1978)	12, 13, 16
"Battlefield Conditions" Reported at Hospital in Inglewood, Los Angeles Times, Dec. 3, 1987, at II-8, col. 4	7
Board Urges Penalty for Doctor, Chicago *Tribune*, Aug. 28, 1988, sec. 2, p. 2	5
California Vital Statistics (1986)	8
Cates, *et al., Mortality from Abortion and Childborth: Are the Statistics Biased?*, 248 J.A.M.A. 192 (1982)	9
Charges Sought Against Doctors in Woman's Post-Abortion Death, Chicago *Tribune*, Mar. 2, 1987, sec. 2, p. 3	5
Correspondence, Ronald N. Kornblum, M.D., Acting CME-Coroner to Hon. Michael D. Antonovich, Chairman, Board of Supervisors, March 16, 1987, March 24, 1987, and May 7, 1987	8
Correspondence, C. Everett Koop, M.D., to President Ronald Reagan, January 9, 1989	9
Grimes & Cates, *Abortion: Methods and Complications*, in Human Reproduction, Second Edition, Reprinted by U.S. Public Health Service, Dept. of Health and Human Services	11
Grimes, *et al., Fatal Hemorrhage from Legal Abortion in the United States*, 157 Surgery, Obstet. & Gynecol. 461 (1985)	11
Hern, W.M., M.D., *Abortion Practice* (1984)	10
Hilgers & O'Hare, *Abortion Related Maternal Mortality: An In-Depth Analysis*, in *New Perspectives on Human Abortion*, 69 (Hilgers, Horan, Mall, ed. 1981)	9, 10

TABLE OF AUTHORITIES—Continued

	Page
Hospital Shut Down as Health Risk Will Reopen for Abortions Tomorrow, Los Angeles *Herald Examiner*, Feb. 12, 1988, at A-1, col. 1	8
Lanska, *et al., Mortality from Abortion and Childbirth*, 250 J.A.M.A. (1983)	10
LeBolt, Grimes, & Cates, *Mortality From Abortion and Childbirth*, 248 J.A.M.A. 188 (1982)	10
National Abortion Federation, *Standards for Quality Care* (1984)	18
"State Regulation of Abortion Clinics," Report to the House Human Resources Committee, Illinois General Assembly, December 13, 1978	6, 12
The 'Abortion Profiteers' Chicago *Sun-Times* Reprint, Nov.-Dec. 1978	*passim*
3 Die After Abortions at Clinic, Los Angeles Herald Examiner, Feb. 22, 1988, at A-1	8
Tragic End to Ghanaian's Dream, Newsday, June 9, 1989, at 6	7
"Under the Knife," Transcript of June 25, 1989 Report of The Channel 2 Investigative Team, WBBM-TV, Chicago	4, 5

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On Appeal from the United States Court of Appeals for the Seventh Circuit

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BRIEF OF FEMINISTS FOR LIFE OF AMERICA AND AMERICAN ASSOCIATION OF PROLIFE OBSTETRICIANS AND GYNECOLOGISTS AS AMICI CURIAE IN SUPPORT OF APPELLANTS

INTEREST OF THE AMICI

Feminists for Life of America ("FFLA") is an organization of pro-life feminists with its national headquarters in Kansas City, Missouri and having state chapters throughout the nation. FFLA and its state chapters engage in educational activities, lobbying and advocacy designed to foster respect for human life and social and economic justice for women. FFLA recognizes that much of the support for abortion on demand as a "solution" for crisis pregnancies stems from motives that are far removed from women's welfare, and that this reality is demonstrated in the abusive, fraudulent and deadly prac-

tices that have flourished at abortion clinics since the legalization of abortion in 1973.

The American Association of Prolife Obstetricians and Gynecologists (AAPLOG) is a national organization of obstetricians and gynecologists founded in 1973 and dedicated to reaffirming the unique value and dignity of individual human life in all stages from the moment of conception. AAPLOG has a particular interest in the impact on maternal health of abortion on demand, and maintains records of reports on maternal deaths resulting from legal abortions. The organization is engaged in educational and research projects which enhance the goals of the organization, including participation where appropriate as an *amicus curiae* in litigation which bears upon these goals.

SUMMARY OF ARGUMENT

The tragic history of abortion practice in Illinois provides the essential context for analyzing the purpose, justification and compelling interest standing behind the Illinois Ambulatory Surgical Treatment Center Act, its related statutory provisions, and regulations. Yet, one combs the opinions below in vain for even the slightest recognition of this history, a history which was manifest in media reports, government investigations, and an official report of a state legislative committee.

This history establishes that in Illinois, maternal mortality and morbidity persist, despite the legalization of abortion. Similar accounts of the dangers of abortion are found in other jurisdictions and are supported by the medical literature. Since the performance of abortions in substandard conditions increases the risk, state licensing of such clinics is essential. Furthermore, both abortion-specific and generally-applicable standards for ambulatory surgical care are medically justified and appropriate.

The majority below, however, applied a rigid, literalist construct of the *Roe v. Wade* trimester framework which

would exclude virtually all but the most minimal regulation of clinics where a vast preponderance of abortions are performed. Furthermore, it accepted without criticism the speculations of the plaintiffs regarding the "burdens" imposed by these regulations, without once considering the burdens which have and will befall women if such regulations are not enforced.

Although the decisions of this Court do not justify the majority's rationale, its decision further exemplifies the impossibility of applying the *Roe* trimester framework in a coherent, predictable manner. "[T]he rigid trimester analysis . . . enunciated in *Roe* has resulted in subsequent cases . . . making constitutional law in this area a virtual Procrustean bed." *Webster v. Reproductive Health Services*, 109 S.Ct. 3040, 3056 (1989). No case has better illustrated this reality, or better stated the need to carefully reconsider and reverse the trimester framework of *Roe*.

ARGUMENT

I. THE STATUTES AND REGULATIONS ADOPTED BY ILLINOIS ARE SUPPORTED BY A CLEAR AND COMPELLING INTEREST IN REDUCING MATERNAL MORTALITY AND MORBIDITY.

A. The Opinions Below Have Rendered Impossible Any Effective Regulation of Abortion Clinics in Illinois, With Tragic Consequences.

The history of abortion practice in Illinois documents the stark and tragic consequences of the failure to vigorously assert the "compelling" state interest in protecting the health of women who undergo abortions. *See Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 828 (1986) (O'Connor, J., dissenting). For years after the legalization of abortion in 1973, over one-third of the abortions performed in Illinois occurred in clinics where women's lives and future reproductive capacity were placed at risk on a daily basis. This legacy of abuse was documented by a five-month

investigation by the Chicago *Sun-Times* and the non-partisan Better Government Association, entitled *The "Abortion Profiteers."*[1] It was further confirmed by state legislators and regulators acting in response to the *Sun-Times*/BGA probe.

As the "Abortion Profiteers" series confirmed, the practice of abortion has frequently attracted the marginally qualified and unscrupulous to its ranks.[2] Had such regulations been enforced in Chicago clinics in the 1970s, as many as a dozen women may not have died, and many more may not have been unduly coerced into abortion, or lost their future ability to bear children.[3] Due to the decisions of the courts below, furthermore, recurrence of such abuse is inevitable. One of the original *Sun-Times*/BGA investigators noted in a June, 1989, report that:

> since 1985, the state has been powerless to even *license* the outpatient surgi-centers that specialize in abortions. It's the result of a court ruling that the state's regulations on abortion facilities were overly burdensome and unconstitutional. *Now literally anyone can open an abortion clinic . . . and there are no standards on how the facilities are staffed or equipped.*[4]

At least one of the original "abortion profiteers," Dr. Arnold Bickham, still operates a clinic in Chicago. Al-

[1] The *Sun-Times* "Abortion Profiteers" series was published commencing on November 12, 1978, and subsequently reprinted. A copy of the reprint has been lodged with this Court in support of the Brief of Certain Illinois Representatives and Senators as Amici Curiae in Support of Appellants. The lodging is hereinafter referred to as "Abortion Profiteers," with pagination being that of the reprint.

[2] "Abortion Profiteers," *supra*, n.1 at 7-9.

[3] The findings of the "Abortion Profiteers" probe are set forth at greater length in Section I-B of this Brief.

[4] "Under the Knife," Transcript of June 25, 1989 Report of The Channel 2 Investigative Team, WBBM-TV, Chicago. (Report by Pam Zekman) (emphasis supplied).

though Bickham has lost his license to practice medicine due to "gross negligence" in connection with the 1986 death of an 18-year old upon whom he performed an abortion, he continues to exercise his "right," protected by the decisions below, to operate an unlicensed abortion clinic on Chicago's south side.[5]

Furthermore, there have been at least two other abortion-related deaths in other Chicago clinics since the State was enjoined by the decisions below from enforcing its licensing requirements.[6] Accurate figures on maternal *morbidity* relating to unlicensed abortion clinics is unattainable, since clinic reporting requirements were another casualty of the rulings below. However, in light of the fact that the 1978 *Sun-Times* investigation discovered 12 abortion-related deaths that were previously unreported by state authorities, it is reasonable to assume that both maternal mortality and morbidity are underreported in Illinois at the present time.

B. The Regulatory Scheme is Supported by Substantial Evidence, from Illinois and Other Jurisdictions, that Maternal Mortality and Morbidity Persist, Despite the Legality of Abortion, Especially Where Regulation is Lax.

The legislative and administrative history plainly establishes that the ASTC Act and regulations were motivated by twin concerns: that all ASTC facilities be licensed to operate under safe conditions, and that the fraud, abuse and outright carnage exposed in the "abor-

[5] *Id.*; *see also* Board Urges Penalty for Doctor, Chicago *Tribune*, Aug. 28, 1988, sec. 2, p. 2; Charges Sought Against Doctor in Woman's Post-Abortion Death, Chicago *Tribune*, Mar. 2, 1987, sec. 2, p. 3 ("Moore bled to death . . . hours after Bickham performed a faulty abortion at the Urgent Medical Care Clinic. . . . Bickham 'forced the patient to leave the clinic office while the patient was in shock and/or otherwise unable to care for herself,' the [civil] complaint charges.")

[6] *See* Report cited in note 4, *supra*.

tion profiteers" exposé be brought to a halt.[7] *See* "State Regulation of Abortion Clinics," Report of the House Human Resources Committee, Subcommittee on Health, Illinois General Assembly, December 13, 1978.[8] A brief review of the findings of the *Sun-Times* and the Better Government Association reveals a record of abortion practice that was somehow foreign to the majority below.

The five-month probe focused on four clinics at which, the investigators concluded, "women's reproductive systems—indeed, their very lives—are endangered every day."[9] These four clinics accounted for more than a *third* of the abortions performed in Illinois in 1977.[10] At these clinics, dozens of abortions were performed on women who were not pregnant.[11] Many women were rendered sterile, and others suffered infection.[12] So-called counsellors "sold" abortions to women, engaging in high-pressure tactics that gave no consideration to risks or alternatives.[13] Abortions were performed by inexperienced, moonlighting residents, physicians whose licenses had been suspended, and physicians convicted of fraud.[14] Patients' vital signs were often not taken.[15] Due to inadequate space, patients were sometimes forced to leave recovery areas within a half hour of their abortion.[16]

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[7] For further discussion of the relevant legislative history, *see* Brief of Certain Illinois Representatives and Senators as *Amici Curiae* in Support of Appellants.

[8] A copy of this Report has been lodged with this Court in Support of the Brief identified in note 7, *supra*.

[9] Abortion Profiteers, *supra*, note 1 at 4 (November 12, 1978).

[10] *Id.*

[11] *Id.*

[12] *Id.* at 1, 11-13 (November 14, 1978).

[13] *Id.* at 7-9, 21-23 (November 13-15, 1978).

[14] *Id.* at 7-9.

[15] *Id.* at 18-19.

[16] *Id.* at 4 (November 12, 1978).

The study also uncovered 12 previously unreported deaths resulting from abortions at Chicago-area clincs, occurring between 1973 and 1978.[17] Several of the deceased women obtained abortions at clinics which were defunct at the time of the on-site undercover investigation. It is fair, based on these deaths, to assume that conditions at these clinics—including the plaintiff clinic in the *Friendship* case relied upon by the majority below—were comparable to those at the four clinics focused on by the *Sun-Times* reports. *See Ragsdale v. Turnock*, 841 F.2d 1358, 1369 (7th Cir. 1988), *citing with approval, Friendship Medical Center, Ltd. v. Chicago Board of Health*, 505 F.2d 1141 (7th Cir. 1974), *cert. denied*, 420 U.S. 997 (1975).[18]

Maternal deaths resulting from abortion are a nationwide phenomenon. The 1989 death of a 28-year-old Ghanaian immigrant after an abortion in an unregulated "storefront" clinic in Brooklyn focused attention on the many operators of such "legal," but unlicensed clinics. "Like many others in New York City, Y.P. Women's & Medical had operated without any monitoring or license from state authorities, a lapse that may have contributed to the death."[19]

In Los Angeles, Inglewood Women's Hospital was eventually closed in February, 1988, after frequent citations for deficiencies by county health officials.[20] However, the clinic operators immediately reopened its abortion business under another name, as an unlicensed clinic not sub-

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[17] *Id.* at 24-27 (November 19, 1978).

[18] *See* Abortion Profiteers, *supra* note 1 at 24 for details of deaths after abortions at the "Friendship" clinic.

[19] *Tragic End to Ghanaian's Dream*, Newsday, June 9, 1989, at 6.

[20] *See "Battlefield Conditions" Reported at Hospital in Inglewood*, Los Angeles Times, Dec. 3, 1987, at II-8, col. 4.

ject to state regulation.[21] At another private, unlicensed clinic in Los Angeles, Her Medical Clinic, three abortions have resulted in deaths since August 1986.[22] The Chief Medical Examiner-Coroner for Los Angeles County has documented 25 deaths related to *legal* abortions in his jurisdiction between 1970 and 1987.[23] At least four of these deaths were *not* previously reported as abortion-related, based upon the California Department of Vital Statistics Death Records for 1983 and 1984.[24]

The common belief that the legalization of abortion has had a dramatic impact in reducing abortion-related maternal mortality is contradicted not only by the documented cases from Chicago, Los Angeles and New York, but also by government statistics. The Centers for Disease Control reported a total of 175 abortion deaths between 1972 and 1981, 83 of which were associated with first-trimester abortions.[25] Experts from the Centers for

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[21] *Hospital Shut Down as Health Risk Will Reopen for Abortions Tomorrow*, Los Angeles Herald Examiner, Feb. 12, 1988, at A-1, col. 1.

[22] *3 Die After Abortions at Clinic*, Los Angeles Herald Examiner, Feb. 22, 1988, at A-1.

[23] *See* Correspondence, Ronald N. Kornblum, M.D., Acting CME-Coroner to Hon. Michael D. Antonovich, Chairman, Board of Supervisors, March 16, 1987, March 24, 1987, and May 7, 1987. Copies of correspondence included in lodging filed with Brief Amici Curiae of Feminists for Life of America, et al., in *Webster v. Reproductive Health Services*, No. 88-605. Copies of the Coroner's reports on most of these deaths is included in the same lodging.

[24] *See* Table A-2, Maternal Deaths by Selected Causes of Death, California, 1960-1984 (By Place of Residence) in *California Vital Statistics* (1986). This table shows *no* abortion-related deaths for the given years. However, irrefutable evidence from death certificates, police reports, coroner's reports and other documents lodged with this Court, note 23, *supra*, indicate that at least four women died from abortions in 1983 and 1984 in Los Angeles County.

[25] *Hodgson v. Minnesota*, 3-81-Civil-538 (D. Minn. 1986), Tr. at 2125 (Testimony of Richard T.F. Schmidt, past president, American College of Obstetricians and Gynecologists, *citing*, *Abortion*

Disease Control (CDC) admit that "it is likely that CDC has not identified all abortion deaths in the United States," and that while CDC's counting of abortion deaths is the most comprehensive available, the CDC numbers "may also reflect an undercount of the true number of total deaths." [26] In a widely-publicized report to the President, former Surgeon General C. Everett Koop noted that despite the difficulty in ascertaining an accurate record of physical and psychological sequelae of abortion, "clearly, however, the incidence of physical injury is greater in instances where abortions are performed or attempted by those not qualified to do them or under less than sterile conditions." [27]

Also, it is clear that both overall and abortion-related maternal mortality have been on a steady downward trend for decades, and "that the legalization of abortion has had no effect" on this already existing trend.[28] Furthermore, claims that "abortion is safer than childbirth" are compromised not only by the likelihood that deaths relating to abortion are underreported, but also by the fact that the methods employed by some statisticians do not present a valid comparison between abortion and childbirth. For example, most studies consider as deaths related to "childbirth" virtually *all* cases of

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Surveillance 1985, U.S. Dept. of Health and Human Services, Centers for Disease Control.)

[26] Cates, *et al.*, *Mortality from Abortion and Childbirth: Are the Statistics Biased?*, 248 J.A.M.A. 192, 193 (1982).

[27] Koop, C. Everett, M.D., Letter to the President, January 9, 1989 at 3. The Surgeon General also noted that accurate assessment of the statistical impact of abortion on women is made difficult by the fact that an estimated 50 percent of all women who undergo abortions "deny having had one when questioned." *Id.* This is further evidence that adverse physical sequelae of abortion may be greatly underreported.

[28] Hilgers and O'Hare, *Abortion Related Maternal Mortality: An In-Depth Analysis*, in *New Perspectives on Human Abortion*, 69, 73 (Hilgers, Horan, Mall, ed., 1981).

maternal mortality not related to induced abortion, whenever they occur. When comparison is made between abortion and natural pregnancy during corresponding periods of gestation, natural pregnancy is shown to be *safer* than induced abortion.[29]

The potential non-lethal complications of induced abortion, although minimized in the testimony of Ragsdale and Hern, have also been documented in the medical literature.[30] Dr. Hern's own textbook acknowledges that "[i]n medical practice there are few surgical procedures given so little attention and so underrated in its potential hazards as abortion."[31] Cates and Grimes, who have consistently advocated the relative safety of abortion,[32] nevertheless acknowledge that in absolute medical and economic terms, the incidence of maternal mortality and morbidity is significant:

> The scope of the problem of abortion complications is large, both numerically and economically. For example, in 1977, nearly 100,000 women in the United States sustained complications of abortion, and 16 died. . . . Excluding the indirect costs of lost productivity, the estimated direct cost of treating women

[29] *See*, Hilgers & O'Hare, *supra*, at 86-89 (comparison of maternal mortality rates from induced abortion and natural pregnancy during first 20 weeks and final 20 weeks of pregnancy); Lanska, *et al.*, *Mortality from Abortion and Childbirth*, 250 J.A.M.A. 361-362 (1983) (correspondence noting maternal mortality rate for *vaginal* deliveries is less than death-to-case rate for legal abortions.)

[30] For further review of the medical literature concerning maternal morbidity related to abortion, *see* Brief of Focus on the Family and Family Research Council as Amici Curiae in Support of Appellants.

[31] W.M. Hern, M.D., *Abortion Practice* 101 (1984).

[32] *See, e.g.*, LeBolt, Grimes, & Cates, *Mortality From Abortion and Childbirth*, 248 J.A.M.A. 188 (1982).

> who suffered complications in 1977 was over $22 million.[33]

Another study by Grimes concedes that although "[n]o woman in the United States should die from hemorrhage caused by legal abortion, [] these deaths continue to occur." The study concluded that a major shortcoming in the management of post-abortion hemorrhage "was delay in recognition of the seriousness of the problem," and that "scrupulous attention to vital signs, visible blood loss and physical appearance is mandatory during the recovery period after abortion."[34] The documented history in Illinois is that thousands of women obtained abortions in clinics where vital signs were "faked," recovery periods were very brief, and symptoms of hemorrhage were ignored.[35]

Induced abortion, therefore, poses a significant risk of maternal mortality and morbidity, a risk which is clearly magnified when abortions are performed by unscrupulous practitioners in unregulated conditions. These findings, which are consistent with the medical literature, the specific experience in Illinois, and the experience in other jurisdictions, provide a compelling basis for state regulation of clinics.

[33] Grimes & Cates, *Abortion: Methods and Complications*, in *Human Reproduction*, 2d ed., Reprinted by U.S. Public Health Service, Dept. of Health and Human Services.

[34] Grimes, *et al.*, *Fatal Hemorrhage from Legal Abortion in the United States*, 157 Surgery, Obstet. & Gynecol. 461, 465 (1983).

[35] *See* Abortion Profiteers, *supra*, n.1 at 18-19 ("pulse, temperature and vital signs often are not measured—they're made up."); at 24-25 (documenting 12 deaths, many from hemorrhage); at 5 ("some clinics with high volume have such small recovery rooms that patients, still in pain, are forced to leave within 15 minutes to make room for the next patient.")

C. Licensing of Abortion Clinics Is the Most Fundamental and Effective Means of Safety Regulation, and the Majority Below Clearly Erred in Holding that the State Could Not Require Separate Regulation of Clinics.

The most effective response to abuse such as that documented in Illinois is to require *licensing* of clinics that perform abortions, to enforce the licensing procedure by verifying the background and qualifications of clinic administrators and physicians, and to inspect clinics on a regular basis.[36] As acknowledged by the majority below, the enforcement of *any* specific ASTC regulations against abortion clinics is dependent upon the basic authority to license such clinics. *Ragsdale v. Turnock*, 841 F.2d 1358, 1371 (7th Cir. 1988), *juris. postponed*, 109 S.Ct. 3239 (1989) ("once the licensing requirement falls, the remainder of the requirements fall with it.") The basic licensing requirement, therefore, is both "reasonably related to generally accepted medical standards, and 'further[s] important health-related state concerns." *Planned Parenthood Association v. Ashcroft*, 462 U.S. 476, 487 (1983).[37]

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[36] The need for stiffer enforcement of licensing requirements was underscored by the subcommittee of the Illinois General Assembly which held public hearings on the clinic abuse exposed by the *Sun-Times*. *See* "State Regulation of Abortion Clinics," note 8, *supra*. The Subcommittee on Health recommended the following: that enforcement of ASTC regulations be stepped up, that licensing fees be *increased* to cover the cost of enforcement, that penalties for operating an unlicensed clinic be increased to $10,000 per day, that the Department of Public Health be authorized to immediately close clinics which pose a threat to public health, and that background checks and financial statements be required of clinics as part of the licensing procedure. *Id.*

[37] The "acute" need of pregnant women for reliable licensing of clinics is noted in a publication of the American Public Health Association:

> Community efforts are needed to assure that abortion services meet high standards. Prospective abortion patients usually want greater confidentiality for this procedure than for most other medical services. Thus the woman is in a particularly vulnerable position because she may be reluctant to complain to any authority concerning the quality of service received. *Since a woman will probably require this service only once in her life, she has no option to change providers as a result of her experience. . . .* The need for unbiased accreditation of all abortion providers, both profit and nonprofit, has, therefore, become acute.

Barnes, *Ambulatory Maternal Health Care and Family Planning Services*, 45, 46 (Committee on Maternal Health Care and Family Planning, American Public Health Association, 1978) (emphasis supplied).

Neither the majority nor Dr. Ragsdale identified any significant burden which is imposed by the licensing requirement *per se*.[38] The majority apparently felt that Dr. Ragsdale did not need to demonstrate the existence of any such burden. 841 F.2d at 1371. Moreover, the "burdens" alleged by Dr. Ragsdale were either *de minimis*, such as increased paperwork (Tr. at 107-110), or related to the *specifics* of the ASTC Act and regulations, such as the "bricks and mortar" requirements, which have never been enforced in full against Dr. Ragsdale.[39]

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[38] The State has taken the clear position that the ASTC Act and regulations are *not* enforced against "occasional" abortion providers. Indeed, in light of the decision of the Illinois Supreme Court in *Village of Oak Lawn v. Marcowitz*, 86 Ill.2d 406, 427 N.E.2d 36 (1981), the State could hardly do otherwise. The majority insisted that, despite the *Marcowitz* opinion, the "risk" of enforcement of the Medical Practice Act and ASTCA against "office-abortionists" remained a justiciable issue. How this could be the case, when the state's highest court has forbade the enforcement of virtually identical regulations in this context, the majority failed to explain. Thus, it is clear that the State was correct below in asserting that the issue of enforcement against the office-abortionist was moot. The majority's stubborn insistence on addressing the issue clearly detracted from its ability to assess the genuine issue at hand: whether the state can license those facilities at which a great majority of abortions in Illinois are performed, and whose track record for safety is blemished.

[39] Although Ragsdale testified that he has never been informed "in writing" that he would not have to comply with the ASTC requirement of a 250 square foot procedure room, he also testified that he passed several state inspections where the absence of such

The majority's most fundamental error in striking the licensing requirement was its failure to distinguish between the type of regulation that is necessary to ensure that abortions are performed in an environment of "maximum safety" for the woman, *Connecticut v. Menillo*, 423 U.S. 9 (1975), and a regulation which imposes an "undue burden" upon access to abortion. Clearly, the requirement that facilities devoted primarily to the performance of abortions be licensed as such, and abide by the same standards of safety as other ambulatory surgical centers, lies in the former category. The only "barrier" to a pregnant woman imposed by this requirement is one that stands between her and a potentially life-threatening abortion.[40]

D. Both the General and Abortion-Specific Provisions Challenged by Respondents Are Justified by Important Interests in Preventing Maternal Mortality and Morbidity.

1. *The Abortion-Specific Regulations Are Valid.*

In Section IV(C) of its opinion, the majority invalidated two abortion-specific provisions, regarding pregnancy testing and pre-abortion counseling, that address specific needs identified in the *Sun-Times* report. One of

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a room had been noted by the inspectors. *Compare* Tr. at 413 *with* Tr. at 410-412.

[40] Other states have also recognized the need for licensing of clinics. The General Assembly of Tennessee, responding to specific documentation of negligence and unprofessional administration of abortion clinics made by the state Department of Health and Environment, recently enacted legislation stiffening the licensing requirements for ambulatory surgical centers which perform abortions. *See*, Senate Bill No. 804, General Assembly of Tennessee, effective June 2, 1989. The legislation included the following findings of fact regarding facilities at which some abortions are performed: unsterile and unsanitary conditions; improper disposal of infectious waste; allowing patients to leave too soon after the abortion procedure; doctors practicing without a license; and improper ventilation. *Id.* For further documentation of the regulation of clinics by other states, *see* Brief of Certain Illinois Representatives, *et al*, note 7, *supra*.

the most egregious abuses was the performance of abortions on women who were not even pregnant. This was not an isolated occurrence, but rather, was the outcome of deliberate strategies to confuse women and "sell" unnecessary surgery.[41] In response, § 205.730(a)(2) of the ASTC regulations requires that: "The physician performing an abortion procedure shall establish the diagnosis of pregnancy *by appropriate clinical evaluation* and testing prior to performing an abortion procedure." (Emphasis supplied). Requiring that a physician spend a few minutes in clinical evaluation to confirm that his patient is pregnant is both medically appropriate and necessary in light of the contrary practices reported by the *Sun-Times* and BGA. Since, in many instances, this is the *only* obstetric procedure this physician will ever perform for this patient, the requirement cannot be seen as unduly burdensome.

The investigators also found that abortions were ruthlessly "sold" to women by "hot line" services that charged high fees, and paid their employees on a commission basis.[42] One clinic operated its own "hot line," directing referrals back to itself.[43] Existing regulations regarding counseling were widely ignored. "[S]ome of the Michigan Av. clinics make a mockery of their mandate. At least one offers no counseling at all. Others make feeble attempts at counseling groups of 10 or more in three minutes or less." [44]

In response, the ASTC regulations mandate minimum qualifications for clinic counselors and for the content of the counseling session. Far from being an "undesired and uncomfortable straitjacket," these requirements are virtually indistinguishable from the informed consent requirement affirmed in *Danforth*: "Counseling shall in-

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[41] *See* Abortion Profiteers, *supra*, note 1, at 4, 32-33.

[42] *See* Abortion Profiteers, *supra* note 1, at 21, 23.

[43] *Id.* at 34.

[44] *Id.* at 4.

clude a discussion of alternatives, description of the procedure to be performed, explanation of risks and possible complications." § 205.730(b)(3).[45] The judgment below, that requiring essential information to be communicated to the woman somehow "intrudes upon the discretion of the pregnant woman's physician," 841 F.2d at 1372, is baffling. The information described is of a general nature, and absolutely essential for the woman to exercise her right to make an informed choice, free of coercion, regarding her pregnancy. Paternalistic discretion over what information to provide should not rest with the abortionist, with whom the woman typically has no true "physician-patient" relationship, but with the woman herself. If this minimal requirement runs afoul of *Akron* and *Thornburgh*, then the time is indeed ripe to overturn those decisions.[46] *See Akron v. Akron Center*, 462 U.S. 416 (1983).

The majority's invalidation of the "no financial interest" requirement of § 205.730(b)(2)(d) results from stubborn refusal to construe the regulation in constitutional fashion. The entire context of this section is obviously directed to *non-physician* counselors. The only sensible construction is that it applies only to counseling

[45] An American Public Health Association publication recommends that "[w]omen should be advised to seek abortion only through *licensed* or accredited facilities and services, having competent, humane counseling services." Barnes, *supra*, note 37, at 47 (emphasis supplied).

[46] The Constitution does not prohibit states from ensuring that the decision of a woman regarding pregnancy be informed. "The decision to abort, indeed, is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences." *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52, 67 (1976). State regulations to ensure that such consent is given "must, from the very rationale for their existence, intrude to some extent on the physician's discretion to be the sole judge of what his or her patient needs to know." *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 830 (O'Connor, J., dissenting). However, this does not provide cause for invalidating such regulations.

by non-physicians. The majority ignored the rationale for this provision: the proliferation of fast-buck artists who ran the abortion referral network in Chicago during the 1970s. However, rather than acknowledge this well-documented reason for affirming this provision, the majority stretched to apply the regulation to persons to whom it was never directed.

The remaining "abortion-specific" requirements of Subpart G of the ASTC regulations are clearly justified. It makes eminent sense for a clinic specializing in abortion to have on its nursing staff at least one R.N. with postgraduate education or experience in obstetrical or gynecological nursing. § 205.720. As the official agency note on this section states, "[p]rocedures involving the pregnant uterus are subject to particular complications and postoperative care requires a special knowledge on the part of the nursing staff." Also, there is a clear public health interest to support the requirements of § 205.760 that clinics submit monthly reports on all abortion procedures and follow-up reports in the event of complications. Such reports would give a far more complete and accurate account of abortion deaths and complications, and prevent practices such as the performance of abortions on non-pregnant women.

2. *The General ASTC Regulations Are Validly Applied to Abortion Clinics.*

By invalidating the general ASTC regulations as applied to abortion clinics the majority has forced the State to negotiate between the Scylla of treating abortion *different* from other medical procedures, and the Charybdis of treating abortion *similar* to other procedures. 841 F.2d at 1370. The majority's standard takes to new heights of absurdity the unfounded requirement that states "narrowly tailor" their abortion regulations to meet compelling state interests. The majority's pretense is unworkable, unfair, and unsupportable by this Court's

rulings. The requirement that abortion regulations be "narrowly tailored" to meet important state interests should thus be formally discarded by this Court.

If evenly applied, the majority's rationale would doom any uniform regulation of ambulatory surgi-centers. Any surgeon who could claim that performance of his or her specialty does not require a 250-square foot procedure room, or venting and circulation requirements to prevent airborne bacteria, could argue that these requirements should not apply to him or her. If such claims were accepted, chaos would result in enforcement of the ASTC rules. If they were rejected, Dr. Ragsdale and his fellow abortionists would have received a benefit unavailable to other physicians who perform minor surgery in non-hospital settings.[47] Contrary to the majority's apparent belief, Ragsdale cannot be distinguished from such physicians on grounds of any "constitutional right." As this Court has emphasized, his right to practice medicine is *not* fundamental, and is subject to reasonable state regulation. *Whalen v. Roe*, 429 U.S. 589, 604 (1977).

Moreover, many of the generally applicable ASTC regulations are supported by accepted medical practice, as set forth by the National Abortion Federation (NAF) [48] and the American College of Obstetricians and Gynecolo-

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[47] In *Hedd Surgi-Center, Inc. v. Turnock*, 711 F. Supp. 439 (N.D. Ill. 1989), the district court held that its opinion in this case only applies to abortion clinics, and that with regard to other types of surgery, the ASTC Act and regulations are to be evaluated as to whether they "bear a rational relationship to a legitimate state interest." 711 F. Supp. at 445. The district court, therefore, has unjustifiably placed Ragsdale's right to operate his own clinic within the zone of "fundamental rights" that are reserved to the *woman* in the context of abortion. *See Whalen v. Roe*, 429 U.S. at 604, n.33.

[48] National Abortion Federation, *Standards for Quality Care* (1984).

gists (ACOG).[49] ACOG holds that "ambulatory care facilities for abortion services should meet the same standards of care for other surgical procedures." [50] Its standards provide specific support for the ASTC regulations concerning the performance of laboratory tests,[51] post-operative care,[52] statistical reports,[53] and informed consent and counseling.[54] Furthermore, ACOG holds that in staffing and administration, a freestanding ambulatory surgical facility *should* be similar to a hospital.[55]

II. ILLINOIS' STATUTORY AND REGULATORY SCHEME FOR REGULATING THE PERFORMANCE OF ABORTIONS IN NON-HOSPITAL SETTINGS IS A VALID EXERCISE OF STATE AUTHORITY TO PROTECT MATERNAL HEALTH.

A. Whether the State Interest in Maternal Health is Labelled "Compelling" or "Important," It Is Clearly Adequate to Support the Regulations at Issue Here.

The majority below assumed that no compelling state interest in maternal health arises before the second tri-

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[49] American College of Obstetricians and Gynecologists, *Standards for Obstetric-Gynecologic Services* (6th ed., 1985).

[50] *Id.* at 62.

[51] *Compare* § 205.520(b)(3) *with* ACOG Standards, *supra*, note 50 at 62.

[52] *Compare* § 205.540 (a), (c), & (d) *with* ACOG Standards at 61-63.

[53] *Compare* § 205.620 *with* ACOG Standards at 83.

[54] *Compare* § 250.730(b) *with* ACOG Standards at 57, 84.

[55] An ASTC "should have a governing body, similar to a hospital board of trustees, that has final authority and responsibility for patient care, facilities, services, appointment of the medical staff, and delineation of clinical privileges. A mechanism similar to that used in the hospital for granting privileges should be established. Privileges granted to a physician should not exceed those held by that physician in at least one accredited hospital within the geographic area." ACOG Standards, *supra* at 3.

mester. However, this presumption is no longer commanded by the decisions of this Court. In *Webster v. Reproductive Health Services*, 109 S.Ct. 3040 (1989), the plurality rejected the rigid trimester framework which confines this important state interest to the latter stages of pregnancy. 109 S.Ct. at 3057. Furthermore, in *Thornburgh*, Justice O'Connor expressly stated that "[t]he State has compelling interests in ensuring maternal health and in protecting potential human life, and these interests exist throughout pregnancy." 476 U.S. at 828 (O'Connor, J., dissenting) (citation omitted), *cited* in *Webster*, 109 S.Ct. at 3063 (O'Connor, J., concurring).

Even prior to *Webster*, *Roe v. Wade* and its progeny did not confer an absolute right to obtain an abortion. "[T]he right of personal privacy includes the abortion decision, but . . . this right is not unqualified and must be considered against important state interests in regulation." *Roe*, 410 U.S. 113, 154 (1973). Furthermore, the plaintiff in *Roe* "had sought to have an abortion 'performed by a competent, licensed physician, under safe, clinical conditions,' [410 U.S.] at 120, and our opinion recognized only her right to an abortion under those circumstances." *Connecticut v. Menillo*, 423 U.S. 9 (1975) (*per curiam*).

Therefore, while *Roe* held that during the first trimester, the interest in protecting maternal health is not sufficiently compelling to justify state interference with the abortion *decision*, "the insufficiency of the State's interest in maternal health is predicated upon the first trimester abortion's being as safe for the woman as normal childbirth at term, and that predicate holds true only if the abortion is performed by medically competent personnel *under conditions insuring maximum safety for the woman.*" *Connecticut v. Menillo*, 423 U.S. at 11 (emphasis supplied).

This Court has also emphasized that the absence of a "compelling" state interest in maternal health in the first

trimester "does not mean that a State never may enact a regulation touching on the woman's abortion right during the first weeks of pregancy." *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 430 (1983). *Akron* acknowledged that maternal health is an "important" state interest throughout the term of pregnancy. 462 U.S. at 428-429. *Akron* further stated that regulations that "have no significant impact on the woman's exercise of her right may be permissible where justified by important state health objectives." *Id.* at 430.

Moreover, prior to *Webster*, this Court rejected the notion that regulations of abortion are impermissible if comparable requirements are not imposed on other medical procedures. *Akron*, 462 U.S. at 430, *citing*, *Danforth*, 428 U.S. at 65-67 and 79-81 (affirming informed consent and recordkeeping requirements, "even though comparable requirements were not imposed on most other medical procedures.") Abortion is not required to be treated the same as other procedures performed by physicians, "because no other procedure involves the purposeful termination of a potential life." *Harris v. McRae*, 448 U.S. 297, 325 (1980). Therefore, "a regulation imposed on a lawful abortion is not unconstitutional unless it unduly burdens the right to seek an abortion." *Akron*, 462 U.S. at 453 (O'Connor, J., dissenting), *citing*, *Harris*, 297 U.S. at 314.

The Constitution, therefore, does not require states to *presume* that first trimester abortions are performed under safe conditions, but rather, allows states to enforce regulatory measures to that end. This is true whether that interest is labelled "compelling," as it should be in the wake of *Webster*, or "important," as even *Roe v. Wade* acknowledged. In light of the record in Illinois, the regulations at issue are presumptively constitutional.

B. The Court of Appeals Followed An Erroneous Standard of "Medical Necessity" in Invalidating the Illinois Statute and Regulations as They Apply to First and Early Second Trimester Abortions.

1. *By Requiring that Abortion Regulations Be Justified as "Medically Necessary," and by Holding that Abortion Cannot be Regulated on the Same Basis as Other Surgical Procedures, the Majority Misconstrued the Pre-*Webster *Standard of Review.*

The majority below applied a virtually absolute standard of strict scrutiny that has never been the position of a majority of this Court, but rather, was derived from two prior decisions of the Seventh Circuit. "[O]ur own case law [is] to the effect that once such regulations are shown to have more than a *de minimis* impact on the abortion decision, the government must show a compelling basis for the law, *i.e.*, that the burden is not undue or unjustifiable." *Ragsdale v. Turnock*, 841 F.2d 1358, 1368 (7th Cir. 1988), *citing*, *Charles v. Carey*, 627 F.2d 772, 777 (7th Cir. 1980) and *Friendship Medical Center Ltd. v. Chicago Board of Health*, 505 F.2d 1141 (7th Cir. 1974), *cert. denied*, 420 U.S. 997 (1975).

In *Friendship*, the Seventh Circuit invalidated a Chicago municipal ordinance similar to the regulations at issue here,[56] and further explained:

> [A]ny proposed regulation, even if applied universally to all similar medical procedures, because of the fundamental right of a woman to procure an abortion during the first trimester, would have to meet a compelling governmental interest requirement. Thus, any general health regulations which would apply to first-trimester abortions would have to be limited so as to give effect to the fundamental rights as established by *Roe* and *Doe*; that is, not be burdensome on a woman's right to decide to abort a pregnancy. *By this we mean that in all probability nothing broader than general requirements as to the maintaining of sanitary facilities and general requirements as to meeting minimal building code standards would be permissible.*

505 F.2d at 1153-54 (emphasis supplied). While the majority contended that *Charles* and *Friendship* are "consistent" with this Court's decisions, this is not so.

First, the Seventh Circuit would require a state to prove that its regulations are not merely "justified" by important health objectives, but are "medically necessary." *Ragsdale*, 841 F.2d at 1368. This has never been the standard adopted by this Court. In *Ashcroft*, this Court did *not*, as the majority claimed, base its holding on a finding that Missouri's required pathology examination report was "absolutely necessary" from a medical standpoint. *Compare* 841 F.2d at 1368 *with* 462 U.S. at 487. Rather, this Court found the pathology requirement to be "reasonably related to generally accepted medical standards," and "clearly 'useful and even necessary *in some cases*.'" 462 U.S. at 487 (emphasis supplied) (citation omitted). Thus, *Ashcroft* cannot be read for the proposition that a health-related regulation of abortion must be universally or even generally *necessary* in order to be upheld.[57] Nor can any other decision of this Court.

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[56] *Amici* note that although the Seventh Circuit in *Friendship* found no basis in the record "for determining whether the regulations are even reasonably related to a valid state concern," 505 F.2d at 1150, subsequent reports indicated that no less than three women died as a result of abortions performed at the Friendship Medical Center alone in 1973 and 1974, and that an additional nine women succumbed after abortions performed at other Chicago-area clinics between 1973 and 1978. *See* Abortion Profiteers, *supra* note 1 at 24.

[57] As this Court noted, the testimony in the district court in *Ashcroft* indicated that "*medical opinion differs widely* on [the] question" of whether a separate pathologist's examination is required after abortion. 462 U.S. at 488-489. One expert witness in *Ashcroft* testified that a separate pathology requirement is "ab-

Second, the Seventh Circuit holds that even if a state imposes identical requirements upon abortion clinics as upon other out-patient surgical clinics, the application of such regulations to abortion must be justified by a compelling state interest. This position, stated as *dicta* in the *Friendship* opinion, was adopted as a holding by the majority below. 841 F.2d at 1369, *citing*, *Friendship*, 505 F.2d at 1153-1154. Thus, regulations which need be only "rationally related" to maternal health in a context other than abortion are invalid as applied to abortion, unless they are shown to be "necessary." *Id.* As Judge Coffey aptly noted in dissent, "the majority carves out an 'abortionist exception' to the general rule that states can reasonably regulate how medical services are provided to its citizens." 841 F.2d at 1377.

This standard is completely inconsistent with *Ashcroft*. Rejecting the plaintiffs' argument that "the physician performing the abortion is as qualified as a pathologist to make the examination," 462 U.S. at 488, and thus, that the Missouri statute requiring examination by a pathologist is unduly burdensome, this Court expressly relied upon the fact that the state required a separate pathologist's examination "after almost every type of surgery." 462 U.S. at 488. This Court further noted:

> No reason has been suggested why the prudence required in a hospital should not be equally appropriate in [an outpatient] clinic. Indeed, there may be good reason to impose *stricter* standards in this respect on clinics performing abortions than on hospitals.

Id. This observation is pertinent in light of the majority's condemnation of the ASTC regulations as requiring abortion clinics "to be the functional equivalent of small

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solutely necessary." 462 U.S. at 489. While this is apparently the source of the quote attributed to this Court by the majority, 841 F.2d at 1368, it clearly does not support the majority's contention that *Ashcroft* adopted the "absolutely necessary" standard as a threshold for constitutional health-related regulation.

hospitals." 841 F.2d at 1368. It is made even more so by the fact that *Ashcroft* cited, as authority, the very documentation of abuse and fraud in the State of Illinois which served as the genesis for many of the regulations at issue here. *Id.* at 488, n.12.

Thus, far from forbidding the states to regulate abortion clinics on a par with other outpatient surgical clinics, *Ashcroft* supports the proposition that the greater propensity for negligence, fraud, and abuse in the practice of abortion—all of which has been well-documented in the State of Illinois and elsewhere—justifies a closer state scrutiny of abortion practice.

2. *Abortion Regulation Need Not Be Narrowly Tailored to That Which Is Necessary to Regulate a Highly-Skilled Practitioner.*

In applying its standard of "medical necessity," the majority below further erred by measuring the "necessity" of the ASTC regulations by whether they are medically necessary for a physician who performs thousands of abortions per year. Since the regulations apply to *all* abortion clinics, and must take into account that all abortionists are not as prolific as Dr. Ragsdale, the majority addressed the wrong question, and arrived at the wrong answer. The appropriate question is whether these regulations are necessary to ensure maximum safety for women *wherever* they may seek an abortion. Judged by this standard, the regulations are clearly valid.

Since any obstetrician/gynecologist is *legally* qualified to perform an abortion, the state is not only concerned with the relatively skillful and experienced practitioner such as Dr. Ragsdale. Rather, the state must be concerned with the standards adhered to by *all* of the physicians who may perform abortions. A physician who performs abortions infrequently may have less-perfected skills, a higher complication rate, and may provide a

more specific justification for many of the regulations at issue.

Furthermore, the state is not required to assume that an abortionist with a high volume of patients, such as Dr. Ragsdale, operates skillfully. As the Abortion Profiteers documented, some of the busiest and most lucrative clinics in Chicago were among the worst in terms of safety.[58] Accordingly, the state should not be forced to custom-tailor its regulations to meet the preferences and convenience of Dr. Ragsdale.[59]

3. *The Court of Appeals Found An Undue Burden on Women's Rights Where None Exists, and Ignored the Genuine Burdens Upon Women Which These Regulations Address.*

In *Ashcroft*, this Court held that the increased cost per abortion of $19.40 caused by the challenged pathology-test requirement "does not significantly burden a pregnant woman's abortion decision." 462 U.S. at 490. The Court also noted that "[i]n weighing the balance between protection of a woman's health and the comparatively small additional cost of a pathologist's examination, we cannot say that the Constitution requires that a State subordinate its interest in health to minimize to this extent the cost of abortions." *Id.* at 429. The majority below, in concluding that a very similar cost increase would "substantially burden" the right to abortion, distorted the holding in *Ashcroft*, ignored the very real burdens upon women which the regulations at issue here will prevent, and found "burdens" upon the right to abortion based on mere speculative testimony.

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[58] Abortion Profiteers, *supra*, note 1 at 7-9.

[59] Ragsdale took the position that many of the ASTC requirements were not essential because they "state the obvious," or require "the kind of thing that any competent medical practitioner would do." *See, e.g.*, Tr. at 140. While Dr. Ragsdale may not like operating under safety regulations which he considers to be superfluous, he has no constitutional claim against such regulations.

The regulations can only be considered a "burden" upon pregnant women if one ignores the history of abortion practice in this state, and treats pregnant women as if their sole constitutional interest is the death of their unborn children. In reality, pregnant women have a constellation of interests, many of which are directly served by the continued operation of this statute and regulations. For women who choose to abort, safety is a paramount concern. It insults the intelligence to suggest that a marginal increase in cost, the price of insuring that *any* clinic a woman chooses in Illinois adheres to the same standards of safety regarding physical plant and procedures, is a "burden" upon women which violates the Fourteenth Amendment.

The need for such uniform regulation is patently obvious. In a vast majority of cases, women undergo abortions at the hands of doctors, and in facilities, with which they are not familiar. This reality has led, in Illinois and in other places, to an opportunity for unscrupulous physicians, would-be physicians, and outright hucksters to profit from the pain of women. This Court, unlike the Seventh Circuit, has not been entirely blind to this reality.

> The professional views that the plaintiffs find to support their position do not disclose whether consideration was given to the fact that not all abortion clinics, *particularly inadequtaely regulated clinics*, conform to ethical or generally accepted medical standards . . . The Sun-Times of Chicago, in a series of special reports, disclosed widespread questionable practices in abortion clinics in Chicago.

Ashcroft, 462 U.S. at 488, n.12 (emphasis supplied).

The record reveals that the only "burden" imposed upon access to abortion is one that was specially manufactured for the occasion of this case. After over a decade of enforcement of the ASTC Act and its thorough regulations to abortion clinics, 22 licensed clinics operate

in Illinois, meeting the state's safety standards, as well as the plaintiffs' perceived "need" for abortion services. The fact that over a score of clinics (fully half the number of *all* ambulatory surgical facilities in Illinois) exist under these regulations is evidence that no substantial burden on access to abortion will be caused by continued enforcement of the regulations. Thus, Dr. Ragsdale was forced to rely on contrived, speculative burdens that are insignificant as a matter of law.

First, Dr. Ragsdale's computation of alleged economic burden upon women who seek abortions is inconsistent, inflated, and incompetent to support a genuine burden upon women.[60] Second, his bald assertion that he would cease to provide abortion services if forced to comply with the ASTC Act and regulations is incredible in light of the lucrative nature of the practice, 841 F.2d at 1391-1392 (Coffey, J., dissenting). It is also irrelevant. Should Ragsdale choose not to operate his practice under such circumstances, someone else is likely to fill the void. *Id.*

Third, Ragsdale's assertion that he is burdened by the act's licensing requirement for facilities primarily devoted to abortion practice is practically laughable. Ragsdale claims that the licensing requirement "creates . . . a public declaration that one is an abortion pro-

[60] In his Certificate of Need (CON) application, Ragsdale stated that his proposed new clinic facility, at a cost of $281,128.00, would not increase cost to the patient. Plaintiffs' Exhibit 11 at 5, 31. Upon the filing of this lawsuit, however, Ragsdale changed his position. He testified that renovations bringing his clinic into *total* compliance with state regulations, at a cost of $218,250.00 (over $60,000.00 *less* than stated on his CON documents) would increase cost to his patients by an additional $47.66. Tr. at 401. Even if this latter position is credible, Ragsdale admitted that $22.45 of this cost would result from measures that he would take to comply with his own standards of medical safety. Tr. at 382-385. Furthermore, of the remaining $25.41, over 80 percent would directly result from physical renovation costs that would be amortized over a 2-5 year period, making the cost of compliance a relatively short-range concern.

vider, and in our society this is a burdensome statement to make in and of itself and creates its own burden." Tr. at 93. Unless one is willing to believe that the Northern Illinois Women's Center is a clandestine operation, and that Ragsdale has managed to attract 42,000 abortion patients over the course of 12 years without publicly disclosing the nature of his practice, it is clear that the "public declaration" imposed by the licensing requirement is cumulative of the public reputation Dr. Ragsdale has willingly cultivated for himself and his clinic.

Fourth and finally, the testimony that "psychological burdens . . . result from having to undergo an abortion in a hospital-like facility when the more psychologically comforting setting of a doctor's office would serve just as well from a medical standpoint," 841 F.2d at 1370-1371, is unvarnished speculation, factually erroneous, and irrelevant. While some patients may prefer an abortion in a doctor's office, others may prefer surgery in a clinic, with a specialist. In addition, Illinois has not enforced these regulations against the occasional performance of abortions in a physician's office, so those who prefer this option remain free to choose it.

C. The Trimester Framework of *Roe v. Wade* Should be Overturned.

This case demonstrates once again the incongruous results of a rigid, literal application of the trimester framework of *Roe v. Wade* by the lower federal courts. In the words of the *Friendship* opinion, 505 F.2d at 1153-54, embraced by the majority below, the *Roe* framework commands that virtually nothing other than general building code regulations can be applied to abortion clinics—even if further regulation is necessary to preserve women's health and lives, and even if the same regulations are applied to other ambulatory surgical treatment centers.

Furthermore, states must so narrowly tailor their regulation of abortion that they honor not only the distinc-

tion between the three trimesters identified in *Roe*, but also account for divisions *within* these trimesters. 841 F.2d at 1369, n.8 ("while the trimester approach remains the applicable legal framework for weighing the competing interests involved in the abortion decision, it does not necessarily follow that all state regulations of abortion which are keyed to it are reasonable.") Thus, it is not even enough to follow the literal dictates of *Roe*; rather, states must somehow divine the everchanging abortionists' state of the art and constantly adjust their regulations to its dictates.

As presaged in the *Webster* plurality opinion, the trimester framework of *Roe v. Wade* should be discarded, and this Court should recognize that the state interest in maternal health, as well as in unborn life, is compelling throughout pregnancy. Thus, the state must be permitted to enforce all regulations which "permissibly further" that compelling state interest. *Webster*, 109 S.Ct. at 3057. The fruits of not applying this standard are seen in the errors of the majority, and more graphically, in the resulting harm to the lives and health of women.

CONCLUSION

The opinion of the Court of Appeals should be reversed.

Respectfully submitted,

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AMICUS CURIAE

BRIEF

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

BERNARD J. TURNOCK, et al.,

Appellants,

v.

RICHARD M. RAGSDALE, et al.,

Appellees.

On Appeal From The United States Court Of Appeals For The Seventh Circuit

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BRIEF AMICI CURIAE OF FOCUS ON THE FAMILY AND FAMILY RESEARCH COUNCIL, IN SUPPORT OF APPELLANTS

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF AMICI CURIAE	1
SUMMARY OF ARGUMENT	2
ARGUMENT	5
I. STATES HAVE BEEN PROHIBITED FROM ENSURING THAT FIRST-TRIMESTER ABORTION IS PERFORMED UNDER CONDITIONS OF MAXIMUM SAFETY FOR WOMEN, DESPITE THIS COURT'S PRONOUNCEMENTS TO THE CONTRARY	5
II. THE *ROE* ASSUMPTION THAT FIRST-TRIMESTER ABORTION IS SAFER THAN CHILDBIRTH IS UNTRUE IN ILLINOIS, AND IS OF DOUBTFUL SCIENTIFIC VALIDITY	10
A. Women Are At Risk From First-Trimester Abortions	10
B. A Substantial Body Of Scientific Evidence Supports The Legitimacy Of Illinois' Abortion Clinic Regulations	13
III. AS RATIONAL RESPONSES TO LIFE-THREATENING CONDITIONS, ILLINOIS' ATTEMPTS TO PROTECT ITS CITIZENS SHOULD BE UPHELD.	23
CONCLUSION	26
APPENDIX	
Table 1: Adverse Physical Effects Of Induced Abortion	1a
Table 2: Adverse Psychological, Psychosocial And Social Effects Of Induced Abortion	7a
Table 3: Adverse Familial Effects Of Induced Abortion	17a
Bibliography For Tables 1, 2 and 3	21a

TABLE OF AUTHORITIES

CASES — Page

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INTEREST OF AMICI CURIAE*

Amicus Focus on the Family is a Christian, nonprofit organization that is committed to strengthening the emotional, psychological and spiritual health of families in the United States and throughout the world. Amicus believes that human life, from conception to death, is of inestimable worth. Its daily radio broadcasts dealing with family concerns and interests are heard by more than one million people daily over 1300 stations. Its monthly magazine has a circulation of 1.7 million. It receives an average of more than 8,000 letters daily, many of which describe the causes and results of past trauma, including the abortion experience.

Amicus Family Research Council, a division of Focus on the Family, is a voice for the pro-family movement in Washington, D.C., and provides policy analysis and research support for Focus on the Family. As such, it studies matters affecting the family, including the effects of abortion.

This case raises questions about the extent to which all states can protect the health of individuals affected by abortion. The Court will review the extent to which states may regulate abortion clinics, particularly clinics that perform first-trimester and early second-trimester abortions. The Court's decision will determine whether general state health regulations may be struck down merely because they have an effect on abortion clinics. The case also provides the Court with an opportunity to clarify its previous holdings in abortion cases, and to review whether the trimester framework bears any relation to the actual harm suffered when abortion occurs. Because

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*This brief is submitted with the written consent of both parties, filed with the Clerk of this Court.

the Court's decision will have a significant impact on millions of American mothers, families and unborn children, *Amici* wish to present their views to the Court.

SUMMARY OF THE ARGUMENT

The Seventh Circuit rejected Illinois' reasonable attempts to protect the health of its citizens. This decision is erroneous for two primary reasons. First, the Seventh Circuit's heightened judicial review eviscerated the State's right to ensure that abortion is performed under conditions of maximum safety for pregnant women, a right that was specifically recognized in *Roe* and its progeny. Second, the decision was based on a rigid application of the trimester framework, even though the underlying assumptions for applying the framework are clearly absent in Illinois.

Illinois passed a series of laws that generally regulated all outpatient surgical facilities, and established standards for medical personnel at those facilities. Abortion clinics were included among those facilities, since abortion is incontrovertibly a surgical procedure. The District Court and the Seventh Circuit Court of Appeals invalidated those statutes by incorrectly applying the trimester analysis constitutionalized in *Roe* v. *Wade*, as expanded in *City of Akron* v. *Akron Reproductive Health Services* and *Thornburgh* v. *American College of Obstetricians and Gynecologists*.

This expansive use of strict scrutiny—applied even where the "burden" on the abortion choice was deemed insignificant—directly controverted other pronouncements by this Court in *Roe* v. *Wade*, *Connecticut* v. *Menillo*, and even in *City of Akron* v. *Akron Center for Reproductive Health Services*. These cases recognized that the trimester framework was based on the assumption that first-trimester abortion was safer than childbirth at term. The decisions agreed that, if the assumption of first-trimester safe abortion were true, the states could not claim to have an overriding interest in regulating maternal health in the first trimester. However, these cases also specifically recognized that the states maintain an interest in ensuring that the assumption remains true.

The assumption is manifestly untrue in Illinois. Legal, first-trimester abortion in Illinois and elsewhere hurts women. Unsanitary conditions, unscrupulous and unlicensed practitioners, abortion "counselors" who receive kickbacks for every woman, pregnant or not, whom they could convince to get an abortion, eventually became known to an outraged Illinois citizenry. Legislative hearings confirmed the documented harm. The need for regulation was apparent even to pro-abortion activists, who recommended a variety of proposed restrictions. Even so, holding that the trimester approach prohibited state regulation if it even "insignificantly burdened" an abortion choice, the Seventh Circuit voided state health regulations that apply to outpatient surgical facilities, including abortion mills.

Illinois' frightening abortion experience undercut *Roe's* tenuous assumption that maternal health is safer in first-trimester abortion than in childbirth, but the assumption is also subject to scientific attack. *Roe's* assumption was based on its 1972 understanding of mortality rates from first-trimester abortion and childbirth. Inexplicably, the Court failed to consider the non-fatal but devastating physical, psychological, social and familial effects of abortion. While experts may debate the validity and methodology of studies proffered on both sides of this issue, one thing is demonstrably true: despite *Roe's* willingness to

embrace the proposition that first-trimester abortion is safer than childbirth for the mother, there is no scientific consensus on this assumption. The assumption thus cannot form the basis of a reliable scientific framework; neither does it suffice as a foundation for constitutionalizing the trimester framework.

Further, abortion mortality rates are unreliable in themselves. Due to judicially-imposed prohibitions on abortion record-keeping, and unwillingness of abortionists to publicize their failures, abortion mortality rates are being underreported. Investigative research, survey evidence and victims' fatal experiences cast significant doubt on the validity of mortality rate comparisons.

Hence, the Illinois abortion experience, scientific and legally cognizable evidence of non-lethal but harmful abortion effects, and underreporting of abortion mortality directly conflict with the *Roe* assumption that first-trimester abortion is safer than childbirth. This dubious assumption cannot provide the basis for disregarding state interests in health during first-trimester pregnancy. State interests in health exist throughout pregnancy, and should be recognized as such.

The Seventh Circuit's rigid application of *Akron* and *Thornburgh* strict scrutiny required it to ignore, as a matter of law, what was apparent to the legislature of Illinois as a matter of fact: even first-trimester abortion significantly harms women. As was recognized by at least four members of the plurality in *Webster* v. *Reproductive Health Services*, the incongruence between the trimester framework and reasonable state regulation and experience is due to problems inherent in the trimester approach, not with reasonable state attempts to respond to health needs. *Amici* respectfully urge this Court to

uphold the Illinois regulations as constitutional, rational exercises of the State's interest in protecting the health of women, an interest that exists throughout pregnancy. Additionally, if the Court believes that Illinois' regulations conflict with the trimester framework, *Amici* urge this Court to abandon the unworkable and outmoded trimester framework, in favor of a rational relationship standard applicable throughout pregnancy.

ARGUMENT

I. STATES HAVE BEEN PROHIBITED FROM ENSURING THAT FIRST-TRIMESTER ABORTION IS PERFORMED UNDER CONDITIONS OF MAXIMUM SAFETY FOR WOMEN, DESPITE THIS COURT'S PRONOUNCEMENTS TO THE CONTRARY.

When the Seventh Circuit court of appeals struck down Illinois' general health regulations as impermissibly infringing on first-trimester abortion, it moved trimester jurisprudence one step further, but moved constitutional jurisprudence one step back. In taking this step, the Seventh Circuit disregarded this Court's pronouncements in *Roe* v. *Wade*, 410 U.S. 113 (1973) ("*Roe*"), and subsequent cases, that permit states to "have a legitimate interest in seeing that [first trimester] abortion, like any other medical procedure, is performed under circumstances that ensure maximum safety for the patient." *Id.* at 150.

Based on the assumption that mortality rates may be less for women undergoing first-trimester abortions than for normal childbirth, the majority in *Roe* held that the states' compelling interest in the health of the mother does not arise until the second trimester, and that therefore states may not restrict the abortion decision in the first trimester. *Id.*, 410 U.S. at 163. At the same time, the Court also recognized that states maintain the right to

ensure that this assumption about maternal health is well-founded:

> Of course, the State retains an interest in ensuring the validity of Roe's factual assumption that "the first trimester abortion [is] as safe for the woman as normal childbirth at term," an assumption that "holds true only if the abortion is performed by medically competent personnel under conditions insuring maximum safety for the woman."

City of Akron v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 430 n. 12 (1983) ("*Akron*") *citing Connecticut* v. *Menillo*, 423 U.S. 9, 11 (1975) (*per curiam*).

Roe had limited the newly-identified right to choose abortion by describing it as less than "absolute" or "unqualified." *Id.* at 154. The right had to be weighed against the states' interests in both the unborn child and the mother's health. *Id.*at 159, 163. However, because it assumed that maternal health was not at risk in first-trimester abortions, the Court embarked on a continuously expanding review of legislative efforts to regulate first-trimester abortion in order to protect the health of women.

Until this Court's recent decision in *Webster* v. *Reproductive Health Services*, 57 U.S.L.W. 5023 (U.S. June 27, 1989) ("*Webster*"), Supreme Court tolerance for state attempts to protect the health of women in the first trimester steadily declined. This intolerance was evidenced by the Court's abandonment of a "rational relationship" standard of review in favor of broad application of a "strict scrutiny" standard. For instance, in *Carey* v. *Population Services International*, 431 U.S. 678 (1977), which struck down certain restrictions on contraception sales to minors, the Court stated that strict scrutiny

should be applied to a state abortion regulation if it imposed a "significant burden" on a protected right, or if the regulation "substantially limited access to the means of effectuating the abortion decision." *Id.* at 689.

Only a few years later the strict scrutiny standard was applied to even *insignificant* burdens on the first trimester abortion decision:

> Certain regulations that have *no significant impact* on the woman's exercise of her right *may* be permissible where justified by important state health objectives.

Akron, 462 U.S. at 430 (emphasis added).

Judicial scrutiny reached a high-water mark in *Thornburgh* v. *American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986) ("*Thornburgh*"), when the Court imposed a *per se* rejection of any regulation that poses even an "unacceptable danger of deterring the exercise of [the abortion] right." *Id.* at 747 (O'Connor, J., dissenting, citing majority opinion at 767).

This extreme application of strict scrutiny was a distant departure from *Roe* and was inconsistent with this Court's standards for review in cases even where *unqualified* constitutional rights are concerned:

> The requirement that state interference "infringe substantially" or "heavily burden" a right before heightened scrutiny is applied is not novel in our fundamental-rights jurisprudence, or restricted to the abortion context. In *San Antonio Independent School District* v. *Rodriguez*, 411 U.S. 1, 37-38 (1973), we observed that we apply "strict judicial scrutiny" only when legislation may be said to have "'deprived,' 'infringed' or 'interfered' with the free exercise of some such fundamental personal right or liberty." If the impact of the regulation does not rise

> to the level appropriate for our strict scrutiny, then our inquiry is limited to whether the state law bears "some rational relationship to legitimate state purposes." *Id.*, at 40.

Akron, 462 U.S. at 462 (O'Connor, J., dissenting).

For a synopsis of the confusion wrought by these abortion-specific standards of judicial review, one need only turn to the court of appeals' decision in this case. Based on Supreme Court and lower court precedent, the court of appeals might have chosen any of the following standards of review for first-trimester abortion regulation: (1) *Akron/Thornburgh per se* rejection of any statute that more than insignificantly burdens an abortion choice, *Thornburgh*, 476 U.S. at 829 (O'Connor, J., dissenting) (describing opinion of the Court, *id.* at 767); (2) approval of the regulation even if it imposes more than an insignificant burden, if it advances a compelling state interest, *id.* at 828, 829 (O'Connor, J., dissenting); (3) approval of "medically necessary" regulations, *see Ragsdale* v. *Turnock*, 841 F.2d 1358, 1368 (7th Cir. 1988), *juris. postponed*, 109 S. Ct. 3239 (U.S. July 3, 1989) (No. 88-790); or (4) approval of state regulation that has a rational relationship to or is "reasonably designed" to promote a legitimate state interest, *Webster*, 57 U.S.L.W. at 5030, 5031 (plurality opinion, Rehnquist, C.J., White, J. and Kennedy, J.). Rather than choose among these standards, the court of appeals referenced all of them, and inexplicably decided that they were all consistent:

> The *[Akron]* language indicates that . . . not only must the impact . . . be *insignificant* . . . *but also* that the regulation must be "justified by important state health objectives." This is consistent with our own language . . . that once such regulations . . . have more than a *de minimis* impact[,] . . . the government must show a *compelling basis* for the law, i.e., that the burden is not *undue* or *unjustifiable*. . . .

> [W]e believe that a "*medical necessity*" standard . . . is entirely consonant with the standards applied to [first-trimester abortion] regulations . . . . [W]hen the experts below testified that a requirement was not "medically necessary" they meant . . . it had *no real relationship* to safety or health.

Ragsdale v. *Turnock*, 841 F.2d at 1368 (citations omitted) (emphasis added).

Unfortunately for the state, the court of appeals blended all these standards into a strict scrutiny review, and struck down all challenged restrictions that applied to abortion.

Legislatures cannot ensure "maximum safety of women" when subject to such limiting and confusing standards. The standards do not reflect constitutional principles, but increasingly arbitrary efforts "making constitutional law in this area a virtual Procrustean bed." *Webster*, 57 U.S.L.W. at 5030, (plurality opinion, Rehnquist, C.J., White, J., and Kennedy, J.). To return this area of the law to sound constitutional principal, this confusing and harmful strict judicial review of state abortion regulation should be abandoned in favor of this Court's long-recognized "rational relationship" standard for reviewing state health and safety regulations. *Williamson* v. *Lee Optical*, 348 U.S. 483, 486 (1955). Failure to do so prohibits states from responding to abortion conditions that threaten the lives of pregnant women.[1]

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[1] *Amici* believe that when abortion occurs, two lives are affected. For the unborn child, the result, almost invariably, is death. For the mother, abortion regularly has the serious adverse consequences discussed in this brief, including death. Because this case presents issues concerning the safety of the mother, *Amici's* brief focuses only on that legitimate state interest. However, inconsistencies with the trimester approach demonstrated herein support greater deference by the courts to state interests, existing throughout pregnancy, in protecting the lives of unborn children.

II. THE *ROE* ASSUMPTION THAT FIRST-TRIMESTER ABORTION IS SAFER THAN CHILDBIRTH IS UNTRUE IN ILLINOIS, AND IS OF DOUBTFUL SCIENTIFIC VALIDITY.

A. Women Are At Risk From First-Trimester Abortions.

Except for the federal courts, public institutions in Illinois have been able to recognize that women who receive first-trimester abortions at legal clinics are being harmed. Illinois newspaper reports, legislative hearings and legislative committee reports documented numerous cases of this harm. In a legitimate exercise of legislative and regulatory discretion, Illinois moved to protect women's health by seeking to regulate the surgical procedure of abortion in much the same way as it regulated other surgical procedures. The rationality of the Illinois regulations is demonstrated by the extensive record of harm with which the State was confronted.

1. **Published Reports.** Officials in the legislative and executive branch of the state of Illinois were faced in the 1970's with numerous reports of life-threatening abortions being administered in largely unregulated but legal abortion clinics. Serious abortion abuses were described in numerous newspaper reports. Zekman and Warrick, "The Abortion Profiteers," *Chicago Sun-Times Special Reprint* (December, 1978).[2] An undercover nurse's aide reported falsified pulse, temperature and blood pressure measurements; unsterile conditions such as failure to wipe up blood from a prior abortion and failure of doctors to wash between abortions; abortions performed without waiting for anesthesia to take effect; women forced to

[2] These articles are included with the lodging of *Amici Curiae* Illinois Senators and Legislators, filed with this Court on behalf of Appellants.

leave the clinic within fifteen minutes after the abortion; and incomplete abortions leaving dead tissue in the womb, at grave risk of infection. "The Abortion Profiteers —Making A Killing In Michigan Avenue Clinics," *id.* at 1. Clinics were reported to be operating without being licensed, and failing to require that those performing abortions were actually licensed physicians. "Meet The Profiteers," *id.* at 7. Abortions were performed on women who were not pregnant. One woman who had an incomplete abortion also suffered a perforated vagina, but her request for an ambulance was denied. Later that night she was rushed to a hospital for emergency surgery. "The Abortion Lottery," *id.* at 11.

Women were forced out of the recovery area prematurely, including one woman who hemorrhaged in a mass transit bus on the way home, and had an emergency hysterectomy that night. Blood tests were confused, and RH blood factors ignored. Sheets were not changed between patients. "Nurse To Aide: 'Fake That Pulse!'" *Id.* at 18. Clinics paid a portion of their abortion fees in kickbacks to abortion referral agencies on the basis of the number of people referred, "Abortion Mills In Huge Kickback Scheme," *id.* at 27-28, and these profit-making abortion "counselors" predictably obtained false-positive results in numerous pregnancy tests, even finding that male urine samples indicated pregnancy. "Soft Voices, Hard Sells," *id.* at 21.

The newspaper discovered twelve deaths from hemorrhages, incomplete abortion and resulting infection, other massive internal infections, punctured uterus and hemorrhage, and a ruptured ectopic pregnancy, although these deaths were unknown to State health officials. One clinic discarded aborted tissue and fetuses despite state law requirements that these must be examined by a

pathologist, since examination permits a determination of whether the patient was actually pregnant, whether the abortion was complete, and whether an ectopic pregnancy may be occurring. "12 Dead After Abortions In State's Walk-In Clinics," *id.* at 24.

2. **Legislative Hearings.** Following the extensive series of reports in the *Chicago Sun-Times*, the Subcommittee on Health of the Illinois General Assembly House Human Resources Committee held two public hearings, and on December 13, 1978 issued a report and recommendations which also recognized the harmful effects occurring from first and early-second-trimester abortions. "State Regulations of Abortion," SUBCOMMITTEE ON HEALTH REPORT TO THE HOUSE HUMAN RESOURCES COMMITTEE, 80th ILLINOIS GENERAL ASSEMBLY, December 13, 1978. ("Subcommittee Report"). Among the 23 restrictions proposed were prohibitions on kickbacks to counselors; requiring all abortion physicians to be board-certified or board eligible in obstetrics and gynecology; imposing a reasonable licensure fee for all ambulatory surgical treatment centers to ensure sufficient resources for adequate state inspections; requiring analysis of aborted tissue and informing patients of analysis results; requiring specific intervals between initial patient exams and surgery; specifying more detailed counseling, and requiring vendor reports of abortion complications. Subcommittee Report, "Summary of Recommendations." The Subcommittee believed that these proposals would not severely restrict the availability or accessibility of abortion. Subcommittee Report, introduction at 1.[3] Even so, many of the restrictions were

[3] It is noteworthy that this evaluation was made by pro-abortion committee members. The report authors displayed a clear bias in favor of abortion. Rather than laying the blame squarely at the feet of the unscrupulous abortionists who were profiting and wreaking such damage on vulnerable women, the report amazingly sought to blame the General Assembly for the abuses by alleging "continuous attempts to overrule the Courts and interfere with the right of women to obtain medical services", and blamed hospitals and private physicians who refused to perform abortions. Subcommittee Report, introduction at 1. Even with this bias, the report authors did not believe their proposals would severely restrict abortion. This report is included with the lodging of *Amici Curiae* Illinois Senators and Legislators, filed with this Court on behalf of Appellants.

never imposed by the legislature.

In light of the extensive review that occurred in Illinois, there was no doubt that many women receiving abortions in the first trimester were being harmed. Illinois' primary response had been to seek to have abortions regulated along with other outpatient surgical treatment facilities, since abortions are indisputably surgical procedures. *Ragsdale* v. *Turnock*, 841 F.2d at 1387 (Coffey, J., dissenting). Unfortunately, hemmed in by the expansive reach of this Court's post-*Roe* decisions, the federal courts responded as if they were precluded from recognizing what almost all of Illinois could see: first-trimester abortions were endangering the lives of Illinois women.

B. A Substantial Body of Scientific Evidence Supports The Legitimacy Of Illinois' Abortion Clinic Regulations.

When the *Roe* majority held that the states' interest in the health of the mother was cut off until after the first trimester, it did so on the assumption that first trimester abortion may be as safe for the woman as normal childbirth at term: 410 U.S. at 163. As described in the previous section, this assumption is directly contradicted by Illinois' actual experience. The assumption is further

invalidated by the substantial body of scientific evidence which, at minimum, suggests that relative safety of first-trimester abortion is not the "now-established medical fact" that *Roe* considered it to be. 410 U.S. at 163.

1. **Abortion-Related Morbidity.**[4] It is beyond question that this Court recognizes non-fatal harm as an important consideration in evaluating the impact of abortion.

> [M]edical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient.

Doe v. *Bolton*, 410 U.S. 179, 192 (1973). *See also Colautti* v. *Franklin*, 439 U.S. 379, 394 (1979), *H.L.* v. *Matteson*, 450 U.S. 398, 405-406 (1981). Inexplicably, however, *Roe* ignored these serious non-fatal effects of abortion when it crafted the trimester framework, and focused only on its understanding of mortality statistics:

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[4] The numerous studies of abortion-related harm reported here and referenced in the Appendix demonstrate that the *Roe* assumption about maternal health is based on judicial fiat, not scientific consensus; it thus cannot justify the first-trimester disregard of state health interests. Studies concerning abortion effects frequently reach differing conclusions. Many suffer from methodological shortcomings and inadequate data, owing at least in part to federal court limitations on state ability to require abortion recordkeeping. Abortion providers often conduct little follow-up of women having abortions, and physicians, mental health care providers and emergency room personnel often are not told of prior abortion experiences. C.f. Lyons, Larson, Huckeba, Rogers and Mueller, Research on the Psycho-social Impact of Abortion: A Systematic Review of the Literature 1966-1985, VALUES AND PUBLIC POLICY 77 (1988). The incidence and severity of negative physical effects documented to date may thus be seriously underreported.

> Mortality rates for women undergoing early abortions . . . appear to be as low or lower than the rates for normal childbirth. *Consequently, any interest of the state in protecting the woman* [in the first trimester] *has largely disappeared.*

Roe, 410 U.S. at 149 (emphasis added).

This failure to consider non-lethal harm is extremely significant when considered with the numerous post-*Roe* studies reporting negative and often permanent physical, psychological, social and familial effects of abortion. The following physical reactions[5] have been associated with abortion: hemorrhaging, subsequent fetal malformations, cervical trauma, ectopic pregnancy, breast cancer, pelvic inflammatory disease, infertility, RH isoimmunization, subsequent miscarriage and death.

a. Low Birth Weight, Pre-Term Deliveries and Spontaneous Abortion in Subsequent Pregnancies From Induced Abortion. A 1980 study conducted by the World Health Organization in nine cities worldwide indicates a significant increase in low birth weight, pre-term deliveries and spontaneous abortion among women whose only previous pregnancy ended in abortion. W.H.O. Task Force, *Gestation, Birth Weight and Spontaneous Abortion in Pregnancy After Induced Abortion*, LANCET.

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[5] See Appendix, Table 1, "Adverse Physical Effects of Induced Abortion," and corresponding bibliography. Because this case focuses primarily on physical conditions associated with abortion, the discussion here is limited to evidence of physical harm. Psychological effects on the pregnant women and harm to the family have also been frequently studied and reported, and significantly undercut the *Roe* assumption of abortion safety. These studies of psychological and familial harm are listed in Appendix, Tables 2 and 3, and corresponding bibliographies, and were described at length in *Amici's* brief to this Court in *Webster*, 57 U.S.L.W. 5023, No. 88-605, 18-28.

Jan. 20, 1979 at 142. Abortions performed in the first trimester have been linked to a significant increase in second trimester spontaneous abortions in the next pregnancy. Ratten and Beischer, *The Effect of Termination of Pregnancy on Maturity of Subsequent Pregnancy*, 1 MED. J. OF AUST. 479 (1979). Women whose first pregnancies were terminated were reportedly 3.4 times more likely to have a mid-trimester spontaneous abortion during their second pregnancy than women whose first pregnancy had resulted in a live birth. Houge, Cates and Tietze, *Impact of Vacuum Aspiration Abortion on Future Childbearing: A Review*, 15 FAM. PLANNING PERSPECTIVE 119 (1983). Women who have had two or more abortions reported a two- to threefold increased risk in miscarrying a subsequent wanted pregnancy. Levin, Schoenbaum, Monson, Stubblefield and Ryan, *Association of Induced Abortion with Subsequent Pregnancy Loss*, 243 J. OF A.M.A. 2495 (1980). A perspective study of teenagers found a high rate of fetal loss in pregnancies that followed abortion. Barron, *Sexual Activity in Girls Under 16 Years of Age*, 93 BR. J. OF OBSTET. & GYN. 787 (1986).

b. Infections, Excessive Bleeding and Perforation of the Uterus From Induced Abortion. Although claims have been made about the relative safety of the abortion procedure, significant medical problems regularly occur. A 1971 study found that among immediate complications of induced abortion were hemorrhages, laceration of the cervix and perforation of the uterus; the three combined were found in 1-2 percent after eight weeks gestation, and in 3.6 percent after 15 weeks or longer. Tietze and Lewis, *Joint Program for the Study of Abortion*, 3 STUDENT FAMILY PLANNING 97 (1971). A study of over 1500 women in 1972 also found that almost 10 percent (96.8 per

1,000 abortions) at 15 weeks gestation or more had perforation of the uterus resulting after suction curettage. Conger, *Cluster of Uterine Perforations Related to Suction Curettage*, 40 OBSTET. & GYN. 551 (1972).

In 1985 the Center for Disease Control in Atlanta, Georgia, estimated that 13,000 post-abortion women per year developed post abortal upper genital tract infection, which is associated with long-term morbidity, including, occasionally, infertility and ectopic pregnancy. *Genital Tract Infection*, 20 OBSTET. & GYN. NEWS 42 (1985) (quoting Kenneth Schulz, Center for Disease Control). In a 1977 Johns Hopkins Medical University study, 5.2 percent of first trimester induced abortion patients and up to 18.5 percent of second trimester patients suffered subsequent genital tract infections. "Occurrence of genital tract infection following elective abortion is a well-known complication." Burkman, *Culture and Treatment Results in Endometritis Following Elective Abortion*, 128 AM. J. OF OBSTET. & GYN. 556 (1977).

Infection from induced abortion in the uterus and fallopian tubes can have severe and permanent effects. A typical infection involving these organs is pelvic inflammatory disease (PID). PID, which is an inflammation of the female genital tract, starts in the cervix and may spread to other female organs and pelvic cavity, and is a major direct cause of permanent sterility, chronic abdominal pain and an increased risk of extra-uterine pregnancy. Rue, *Pelvic Inflammatory Disease and the Role of Induced Abortion*, ASSOC. FOR INTERDISCIPLINARY RESEARCH NEWSLETTER 4 (Summer 1988). Induced abortion is responsible for an estimated 150,000 to 250,000 cases of the over 1 million PID cases annually in the United States. *Id.*, at 4. The total cost of PID and PID-associated ectopic pregnancy and infertility in the

United States exceeded $2.6 billion in 1984 and will exceed $3.5 billion by 1990. Washington, *Economic Cost of Pelvic Inflammatory Disease*, 255 J. OF A.M.A. 1735 (1986).

c. Ectopic Pregnancies from Induced Abortions. "[T]he increased incidence of PID—especially from chlamydia—in induced abortion appears to play a leading role in the dramatic rise in ectopic pregnancies." Barber, *Ectopic Pregnancy: A Diagnostic Challenge*, 9 THE FEMALE PATIENT 10 (1984). In 1970, the incidence of ectopic or tubal pregnancy was 4.8 per thousand live births; by 1980 it was 14.5 per thousand births, a 300 percent increase in only a decade. U.S. Dept. HHS, 15 MORBIDITY AND MORTALITY WEEKLY REPORT 33 (1984). Though the death rate from ectopic pregnancies has fallen during this time span due to medical and technological advances, it still accounts for over 10 percent of all maternal mortality. Atrash, *Ectopic Pregnancy in the United States, 1970-1983*, 35 MORBIDITY AND MORTALITY WEEKLY REPORT 225 (1986). A 1982 study found that the crude relative risk of ectopic pregnancies after one prior induced abortion is 1.6 and after two or more induced abortions is 4, which was significantly higher than the control group. Levin, *Ectopic Pregnancy and Prior Induced Abortions*, 72 AM. J. OF PUBLIC HEALTH 253 (1982).

d. Sterility and Other Physical Complications From Induced Abortion. Out of 752 mothers interviewed during a pregnancy subsequent to abortion, a study revealed an excess in malformations in birth and other pregnancy complications, such as bleeding, low birth weight, manual removal of placenta, and a two- to three-fold increase in neonatal deaths. Harlap and Davies, *Late Sequelae of Induced Abortions: Complications and Outcome of Pregnancy and Labor*, 102 AM. J. OF EPIDEMIOLOGY 217 (1975). Other documented complications from induced abortion have been RH isoimmunization, breast cancer, cervical injuries, and a history of multiple menstrual problems. Leong, Duby and Kinch, *Fetal Maternal Transfusion Following Early Abortion*, 54 OBSTET. & GYN. 424 (1979); Pike, *Oral Contraceptive Use and Early Abortion as Risk Factors for Breast Cancer in Young Women*, 43 BR. J. OF CANCER 72 (1981); Schulz, Grimes and Cates, *Measures to Prevent Cervical Injuries During Suction Curettage Abortion*, 1983 LANCET 1182; Roht, Fonner, Aoyama and Fonner, *Increased Reporting of Menstrual Symptoms Among Women Who Used Induced Abortion*, 127 AM. J. OF OBSTET. & GYN. 356 (1977), respectively. "A 1976 study showed that the relative risk of secondary infertility among women with at least one induced abortion and with no spontaneous miscarriages was three to four times that among non-aborted women." Trichopoulos, *Induced Abortion and Secondary Infertility*, 83 BR. J. OF OBSTET. & GYN. 645 (1976).

The physical hazards of abortion are often visited on unsuspecting women, rushed through abortion mills, with disastrous results. Assembly line abortion practices too often pursue profit at the expense of safety. For instance, Dr. Edward Allred, whose chain of abortion clinics performs 60,000 abortions per year, reportedly grossing twelve million dollars annually, recently described the context in which women undergo abortions: "Very commonly we hear patients say that they feel like they're in an assembly line . . . . *It is an assembly line* . . . . We're trying to be as cost effective as possible and speed is important." *"Doctor's Abortion Business Is Lucrative."* The San Diego Union, Oct. 12, 1988 at 3A, col. 5 (emphasis added). This attitude is not unique:

> Doctors callously perform abortions in an excruciating 2 minutes, when they should properly take 15 minutes, and doctors don't even wait for pain-killing anesthetics to take effect . . . . the doctors race each other. Especially on Saturdays, they compete to see who can get the most patients done. *The Abortion Profiteers*, *id.* at 1-2.

One woman's experience shows how harmful these practices are:

> Well, I can't have kids now. It's really hard at times to know I gave up my only chance of having a family of my own. At least two times a year I cry my eyes out all night long over that fact. I know that God has forgave me. But it's hard to forgive myself. Everytime I see a baby I want one. And I know I can't have one. Cause, I had an abortion when I was just 14 years old.

Brief *Amici Curiae* Focus on the Family and Family Research Council, *Webster* v. *Reproductive Health Services*, 57 U.S.L.W. 5023, No. 88-605.

Medical complications from induced abortions thus can be severe and permanent, and repeat aborters increase their risk of physical complications. Many of the reports referenced here describe effects that are not discovered until much later, or until subsequent attempts at pregnancy. Yet all of these serious side effects were ignored in formulating the trimester approach, when the Court narrowly focused on its understanding of mortality rates.

Since 1972, the number of abortions have dramatically increased from 587,000 to 1,589,000 in 1985, a 260 percent increase. If only a small percentage of women having induced abortions experience one or more of those physical problems, the overall effect on women is significant, and worthy of State regulation and protection.

2. **Abortion-Related Mortality.**[6] Even when morbidity of first-term abortion is ignored, as the *Roe* majority did in establishing the trimester framework, the *Roe* assumption that first trimester abortion is safer for women than childbirth at term is unjustifiable. First, even the *Roe* majority qualified this assumption: "[F]irst trimester mortality on abortion *may be* less than mortality in normal childbirth." 410 U.S. at 163 (emphasis added). The use of the conditional tense displays the majority's discomfort with the "well-established medical fact" that first-trimester abortion is relatively safe. *Id.* If, as *Roe* stated, this "fact" "may be" true, it is not a fact, but an unproven theoretical assumption. Nevertheless, the Court seized on that unproven assumption as *the* rationale for constitutionalizing the artificial distinction between the first and second trimesters, and cutting off the states' interest in protecting maternal health in the first trimester.[7]

Second, there is reason to believe that abortion mortality is systematically underreported in this country. For instance, Illinois public health officials were unaware that the twelve maternal deaths, discovered by the *Chicago Sun-Times* at only four abortion facilities, were abortion-

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[6] For additional discussion of abortion-related mortality effects, *see* brief of *Amici Curiae* Feminists for Life, *et al.*, filed with the Court in this matter.

[7] *Roe's* careful use of the phrase "may be" was unjustifiably changed to "is" in *Akron* by a bracketed insert: ". . . first trimester abortion [is] as safe for the woman . . . ." 462 U.S. at 430 n. 12. This insertion disguised the actual lack of certainty in this assumption. Unfortunately, no data was advanced to justify the change. The court of appeals in the case below inadvertently contributed to this unjustified certainty by deleting the brackets in quoting *Akron*. *Ragsdale* v. *Turnock*, 841 F.2d at 1367.

related. "12 Dead After Abortions in State's Walk-in Clinics," The Abortion Profiteers, *id* at 1. Similarly, in Los Angeles County, the chairman of the committee which tracks maternal deaths admitted that he was personally aware of twice as many abortion-related deaths as were officially reported, and that he felt these were only a small portion of total abortion-related deaths in the county. J. Wilke and B. Wilke, HANDBOOK ON ABORTION 78-80, 89 (1979).

Other surveys also suggest significant and systematic underreporting of abortion mortality. Legal abortions were available in this country since 1968. From 1968 to 1974, only 52 total deaths from legal abortion were reported as such. When 486 of the nation's 21,700 obstetricians were surveyed in 1974, 29 reported having had one or more patients die as a result of a legal abortion. If this 52-death figure is accurate, then one of two conclusions must be true: either these 29 obstetricians happened to have seen more than half of all legal abortion deaths in this country up to that time, or legal abortion deaths were grossly underreported. D. Reardon, ABORTED WOMEN: SILENT NO MORE 110 (1987).

Even if it were true that maternal mortality is lower in first-trimester abortion than in childbirth, it does not follow that the state must abandon its long-recognized interests and discretion in determining what regulations best protect the health of its citizens in the first trimester. *Akron*, 462 U.S. at 460 (O'Connor, J., dissenting). This interest is not being protected by abortion providers. As appellees' own trial expert has stated: "In medical practice, there are few surgical procedures given so little attention and so understated in its potential hazards as abortion." W. Hern, ABORTION PRACTICE 101 (1984). This inattention can have disastrous results:

> On April 11, 1985, while Debra [my daughter] was on Easter vacation, she went to the abortion clinic, accompanied by her girlfriend. There, the abortion was performed without adequate care. They did not monitor Debra during the procedure. No airway was inserted and during the surgery Debra swallowed her tongue. The attendants at the clinic were unable to restore her breathing and consciousness to normal. I was called at work by the Director of the clinic, who informed me that my daughter was at the clinic [without my knowledge or consent] for 'minor surgery' and that she was having some respiratory problems. They rushed Debra to the hospital, where she lay in a coma for two and a half months. Debra died on June 21, 1985.

Brief *Amici Curiae* of Focus on the Family, *et al.*, *Ohio* v. *Akron Center for Reproductive Health*, No. 88-805 (U.S. 1989) at Appendix A, 8a.

III. AS RATIONAL RESPONSES TO LIFE-THREATENING CONDITIONS, ILLINOIS' ATTEMPTS TO PROTECT ITS CITIZENS SHOULD BE UPHELD.

In light of *Akron* and *Thornburgh*, the Seventh Circuit decided that it was constrained as a matter of law to reject Illinois' actual experience with life-threatening conditions, even when those conditions are apparent as a matter of fact. For instance, in rejecting state application of physical plant health requirements to abortion clinics, the court of appeals found that:

> Many of the physical plant . . . regulations are designed with procedures to be performed under general anesthesia in mind, although . . . first and early second-trimester abortions . . . are *not usually* performed under general anesthesia . . . . [I]n fact, a general anesthetic increases the risk of death and major complications from such procedures.

Ragsdale v. *Turnock*, 841 F.2d at 1370 (emphasis added).

The court thus recognized, at least inferentially, that general anesthesia is used occasionally at first and second trimester abortion clinics, and that it *increases the risk of death*. *Id.* Rather than defer to State health officials even where such an obvious State interest is involved, the court of appeals struck down application of this and other general medical regulations to abortion clinics.

Further, the Seventh Circuit substituted its medical judgment for the State, and even for the evidence adduced at trial, in determining that the State only labeled abortion as surgery to impose irrelevant health regulations. *Id.* at 1387. The plaintiff's own medical experts testified that abortion is a surgical procedure. *Id.* As the dissent points out:

> . . . the majority once again disregards the record and strays far afield from its area of legal competence and makes medical judgments and pronouncements that are more properly reserved to those expressly trained in the medical scientific fields. . . .

Id. at 1387 (Coffey, J., dissenting).

This anomalous result is the product of narrow and inconsistent judicial rules, based on an "unworkable scheme for constitutionalizing the regulation of abortion . . .". *Thornburgh*, 476 U.S. at 815 (O'Connor J., dissenting). The impact of *Akron*, *Thornburgh* and the decisions below is far removed from that anticipated by this Court when *Roe* was decided. *Id.*, 476 U.S. at 783 (Burger, C.J., dissenting). Those holdings result in rejection of legitimate state statutes that "would have been sustained under any traditional standard of judicial review," *Webster*, 57 U.S.L.W. at 5030, *citing Thornburgh*, 476 U.S. at 802 (White, J., dissenting). "*Roe* did not purport to adopt a whole framework, complete with detailed rules

and distinctions, to govern the cases in which the asserted liberty interest would apply." *Webster*, id. at 5031.

The Seventh Circuit did not have the benefit of this Court's reasoning in *Webster* when it rejected Illinois' statute and regulations. In *Webster*, four justices in the plurality would have applied nothing greater than a "rational basis" standard of judicial review in abortion cases, as this Court does in reviewing other state health and safety regulations. They have signaled their "abandonment of the trimester framework." 57 U.S.L.W. at 5030, n.15 (Rehnquist, C.J., joined by White, J., and Kennedy, J.), id. at 5034 (Scalia, J., concurring in part and concurring in judgment). Justice O'Connor found it unnecessary to reconsider the trimester approach, since she believed that the Missouri statute in question—requiring certain tests as are necessary to determine viability—would not unduly burden the decision to have an abortion. 57 U.S.L.W. at 5033 (O'Connor, J., concurring in part and concurring in judgment). Under any of these tests, Illinois' regulations should be upheld.

In this case, the Seventh Circuit's application of strict scrutiny, resulting in rejection of Illinois' reasonable health and safety regulations, was based on *Akron's* and *Thornburgh's* rigid truncation of state interests in maternal health prior to the second trimester. The state interests in protecting maternal health and the lives of unborn children exist throughout pregnancy. *Webster*, 57 U.S.L.W. at 5030-31. This conclusion is supported by reference to this Court's long recognition of state authority to rationally regulate health and safety matters, *Williamson* v. *Lee Optical Co.*, 348 U.S. 483, 486 (1955). Just as significant, however, is the unsupportable assumption, which is the foundation of the first and second trimester distinction, that maternal health is safer in

first-trimester abortion than in childbirth at term. This assumption is, at minimum, the subject of great scientific debate. It is rejected by Illinois' real experience. It cannot provide a basis to sever the states' ability to protect their citizens.

CONCLUSION

The decision of the court of appeals should be overturned. The trimester approach, with its varying standards of review, should be abandoned in favor of a rational basis judicial standard of review for state abortion regulation.

Respectfully submitted,

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APPENDIX

APPENDIX

TABLE 1

Adverse Physical Effects of Induced Abortion (By Year)

Researcher(s)	Date	Major Findings
Klinger	1971	After one legal abortion, premature births increase by 14%; after two abortions, by 18%; and after three, it increases to 24%.
Tietze and Lewis	1971	Immediate complications of induced abortion (hemorrhage, laceration of the cervix and perforation) totaled 1-2% after eight weeks gestation and 3.6% at 15 weeks or longer.
Conger	1972	From a study of 1,668 women, perforation occurred using suction curettage in 96.8 per 1,000 abortions at 15 weeks gestation or more.
Harlap and Davies	1975	752 mothers interviewed during subsequent pregnancy revealed an excess of malformations in births and pregnancy complications, such as bleeding, low birth weight, manual removal of placenta and two-to-threefold increase in neonatal deaths, following earlier induced abortions.
Roht, Aoyama, Leinen and Callen	1976	Prior induced abortions appear to be associated with excess prematurity and spontaneous abortions in subsequent prenancies. Unfavorable subsequent preg-

TABLE 1—Continued

Researcher(s)	Date	Major Findings
		nancy outcomes increase with frequency of induced abortions.
Trichopoulos	1976	"The relative risk of secondary infertility among women with at least one induced abortion and no spontaneous miscarriages was 3-4 times that among non-aborted women."
Burkman	1977	"Occurrence of genital tract infection following elective abortion is a well-known complication." Johns Hopkins University reports rates up to 5.2% for first trimester and up to 18.5% in second trimester.
Roht, Fonner, Aoyama and Fonner	1977	Survey of 3,222 showed a consistently-reported excess of menstural symptoms among women with history of induced abortion.
Bracken	1978	Abortion by dilation and curettage (D&C) may increase the risk of subsequent spontaneous abortion, low birth weight and prematurity, but these findings need further confirmation.
Cavenar, Maltbie and Sullivan	1978	Report of psychogenic abdominal pain after abortion and anniversary reactions.
Harlap, Shiono, Berendes and Pellegrin	1979	Study revealed 120% increase of mid-trimester spontaneous fetal losses among nulleparous women with previous induced abortions and the relative risk increased with

TABLE 1—Continued

Researcher(s)	Date	Major Findings
		the number of previous induced abortions.
Leong, Duby and Kinch	1979	A random survey/study of 75 women whose pre- and post-abortion smears were studied revealed therapeutic abortions to be a major potential source of RH isoimmunization.
Ratten and Beischer	1979	Therapeutic abortions performed in first trimester were linked to a significant increase in second trimester spontaneous abortions and premature labor in next pregnancy.
W.H.O. Task Force	1979	Significantly higher risk of mid-trimester spontaneous abortion, preterm delivery, or low birth weight among women whose only previous pregnancy ended in an induced abortion.
Levin, Schoenbaum, Monson, Stubblefield and Ryan	1980	Comparison of women who had multiple abortions and women who had term delivery revealed two-fold-threefold increased risk of subsequent pregnancy losses for women with multiple induced abortions.
Brautigam and Wainke	1981	Induced abortion was statistically more frequent precedent to late complications, such as abdominal pregnancy, retarded abortion, cervical insufficiency or imminent pre-

TABLE 1—Continued

Researcher(s)	Date	Major Findings
		mature births, than in the control group. Induced abortions beyond the 8th week involve even more frequent late complications in subsequent pregnancy.
Pike	1981	First trimester abortion before full term pregnancy showed a 2.4-fold increase in risk of breast cancer.
Slater	1981	Infants born following a previous induced abortion by D&C showed excessive low birth weight due to damage to cervix from D&C. The greater the degree of dilation, the greater the cervix damage which leads to increase in low birth weight.
Levin	1982	Relative risk of ectopic pregnancy was 1.6 for women with one prior induced abortion and 4.0 with two or more, which is significantly higher than control group.
Qvigstag	1982	Patients harboring chlamydia trachomatis in the cervix at termination of pregnancy are at high risk of developing postoperative infections such as PID, salpingitis and detectable chlamydia antibodies. Chlamydia trachomatis was cultured from the cervix in 70 of 557 women admitted for therapeutic abortion. Among the 70, 22 developed acute PID postoperatively.

TABLE 1—Continued

Researcher(s)	Date	Major Findings
Westergaard	1982	Presence of chlamydia in the cervical canal at the time of an induced abortion in asymptomatic women increases risk of postabortal PID from 10% to 28% in 333 women studied.
Schulz, Grimes and Cates	1983	Cervical injury, which is one of the most frequent complications of suction curettage abortion, occurs in about 1 per 100 abortions in study of 15,438 women. Such micorfracture of the cervix may lead to cervical incompetence, premature delivery and other pregnancy complications.
Tollesfson and Garvey	1983	Case analysis of the evolution of a woman's conversion disorder (urinary retention) in response to a decision to terminate pregnancy. Concluded that a variety of psychological disorders may go undetected concerning abortion and present themselves as "unrelated" physical complaints without organic basis.
Dicker, Feldberg, Samuel and Goldman	1985	Association of cervical pregnancy and induced abortion with traumatic curettage damaging the endometrium, rendering it unsuitable for nidation, was well documented.
Heisterberg	1985	PID is major complication of

TABLE 1—Continued

Researcher(s)	Date	Major Findings
		induced abortion occuring in 2-20% of women who had an abortion.
Pickering and Forbes	1985	Women with previous induced abortions experienced significantly increased risk of pre-term delivery.
Wong, Wong and Chang	1985	A history of previous abortions was significantly more common in the group displaying meconium stained amniotic fluid during labor.
Barron	1986	Compilation of data from British and American publications showed over half of the pregnancies in girls under 16 ended in induced abortion and a prospective study of teenagers found a high rate of fetal loss in pregnancies that followed abortions.
Darj	1987	Scandinavian studies reveal that PID following induced abortion ranges from 6-13%.
Rue	1988	Induced abortion is estimated to be responsible for 150,000-250,000 cases of PID in the U.S. annually. PID is a major direct cause of permanent sterility, chronic abdominal pain and increased risk of extrauterine pregnancy.

TABLE 2

Adverse Psychological, Psychosocial and Social Effects of Induced Abortion (By Year)

Researcher(s)	Date	Major Findings
Jansson	1965	An analysis of numerous major studies, i.e. Ekblad (1955), Aren & Amark (1957), Hultin & Ottosson (1962), Lindberg (1948), Hook (1963), Jansson (1963) and Freundt (1964), showed mental insufficiencies strikingly more common after induced abortions than other abortions or delivery. Induced abortion adjudged fairly ineffective as a psychiatric therapeutic means.
Bracken and Suigar	1972	Self-reported negative abortion reactions were associated with being unmarried, young and lacking support from partner and parents.
Osofsky and Osofsky	1972	16% of abortion patients were judged unhappy and 25% expressed guilt.
Kaltreider	1973	Reported on the increased emotional difficulties in midtrimester abortion patients, noting that those women who perceived the fetus as a human being, i.e. baby, felt more guilty or sad.
Ewing and Rouse	1973	19% of post-abortion patients expressed immediate negative reactions, especially if there was a prior history of emotional disturbance.

TABLE 2—Continued

Researcher(s)	Date	Major Findings
Moore-Caver	1974	Review of abortion literature found severe guilt in 2-23% of patients.
Blumberg, Golbus and Hanson	1975	Selective abortions for genetic defects produced depression in 92% of women and 82% of men and had severe psychological effects on families. Negative effects for selective abortions far greater than for delivery of stillborn.
Lask	1975	Of 50 abortion patients, 32% had adverse outcomes, reporting moderate to severe feelings of guilt, regret, loss and self-reproach.
Greenglass	1976	12% of aborted women experienced negative psychological reactions with 3% attempting suicide. Psychiatric patients pre-abortion were three times as likely to require therapy post-abortion.
Kent	1977	Abortions in patients' histories were major precipitants in seeking psychotherapy.
Gerrard	1977	Sexual inhibition and guilt was found to be significantly higher for women who have undergone abortions than for nonpregnant women.
Belsey, Greer, Lal, Lewis and Beard	1977	An emotional attitude study of 360 women before and three months after first trimester abortion revealed 161 women displaying one or more features of emotional disturbance. Degree of adjustment

TABLE 2—Continued

Researcher(s)	Date	Major Findings
		before pregnancy was the dominant influence and major factor in predicting emotional disturbances.
Bracken	1978	15% of the sample experienced a difficult abortion decision, anxiety, depression and pain.
Spaulding and Cavenar	1978	Reported significant post-abortion guilt, psychoses, consternation and anniversary reactions.
Brewer	1978	20% of sample reported negative psychic trauma from induced abortion.
Kumar and Robson	1978	119 primiparae were interviewed during the 12th and 36th week of pregnancy. In a significant proportion of these expectant mothers there was an association between depression and anxiety early in pregnancy and a previous history of induced abortion, suggesting a reactivation of mourning which was previously suppressed.
Mester	1978	Induced abortion is a stressing experience and for some women may be traumatic. Psychotherapists may be ignoring or minimizing the importance of the abortion experience for certain kinds of patients in pain.
Morrissey and Schuckit	1978	Problem drinkers and secondary alcoholics were more likely to have experienced an alcohol-related

TABLE 2—Continued

Researcher(s)	Date	Major Findings
		problem subsequent to an abortion.
Liebman and Zimmer	1979	Reported 24 immediate and long-term post-abortion abreactions affecting self image, relationships, and future coping abilities.
Proud	1979	Women who have aborted reported lower total self concept, including moral-ethical self, physical self prespective, and social self, and were significantly more defensive than those not aborting. In addition, post-abortion women have higher neurotic scores and lower personality integration. In short, in most areas, aborting women reported lower levels of self concept.
Somers	1979	Of 597 Denmark women, aborting women under 30 exhibited higher psychiatric admission rates than did women of this age in general. Teen aborters had the highest rate of psychiatric admission (2.9 times the rate of teenagers in general).
Adler	1979	Abortion is a stress experience. A sense of loss influences stressful, negative emotions. Responses to the experience will be a function of the nature and meaning of the pregnancy to the individual, her defensive and coping style, and her social environment.

TABLE 2—Continued

Researcher(s)	Date	Major Findings
George	1980	Women who sought abortions scored higher than controls on neuroticism and manifest anxiety.
Freeman, Rickels, Huggins, Garcia and Polin	1980	Study of 413 women revealed elevated stress levels prior to abortion, particularly depression, anxiety and somatization, and after abortion, *repeat* aborters continued to have significantly higher emotional distress scores in interpersonal relationships.
Ashton	1980	A study of 64 women after eight weeks and 86 women after eight months revealed short-term psychiatric disturbances, including guilt, regrets and sensitivity to comments about the abortion, and 5% suffered enduring severe psychiatric problems post-abortion.
Cates	1980	Relatively more teenagers than older women suffered anxiety, depression, sadness, guilt and regret.
Gould	1980	A study examining health experiences of Harvard women post abortion revealed post-abortion depression, anniversary reactions, guilt and despair.
David, Rasmussen and Holst	1981	In a nationwide hospital study in Denmark, psychiatric problems were significantly higher in women who had abortions than women

TABLE 2—Continued

Researcher(s)	Date	Major Findings
		who delivered or women in general. Negative post-abortion reaction was worse for women not in a relationship.
Tishler	1981	Case studies of two adolescent females who had elective abortions illustrate increased psychosocial stress of adolescent abortion which could include suicide on the anniversary date the fetus would have been born.
Williams and Ventimiglia	1981	To minimize negative post-abortion reaction, women should seek support from significant others, be apprised of procedures, be familiar with alternatives and recognize medical and emotional costs.
Handy	1982	Women seeking termination demonstrated more psychological disturbance than other women. Few women found the decision to terminate easy.
Baker and Quinkert	1983	Data from 252 women who experienced reproductive problems (including abortion). Depression and increased stress were found which improved as the subjects learned more about the problem and drew closer to their families and others with similar problems.
Cohen and Roth	1984	From a study of 55 women, post-abortion stress was displayed at

TABLE 2—Continued

Researcher(s)	Date	Major Findings
		fairly high levels. Evidence revealed a "generalized stress response syndrome." "Avoiders" were found to experience more distress than "nonavoiders."
Bradley	1984	Women who had a prior abortion scored higher on levels of depressive effect in the third trimester of pregnancy and in the postpartum period.
Franco	1984	Women reporting multiple abortions had more often considered suicide and scored higher on borderline personality pathology and depression. 40% of the 71 women studied reported anniversary reactions. Half of the women aborting sought psychotherapy after the procedure.
Gold	1984	At the four-week follow-up, abortion patients had poorer psychological adjustment than maternity patients; married abortion group reported less satisfying relationships with their husbands, and also reported poorer psychological adjustment.
Frank	1985	Morbidity within 21 days after induced abortion which was related to that event was found in 10% of 6,105 women who had induced abortions.

TABLE 2—Continued

Researcher(s)	Date	Major Findings
Jorgensen, Uddenberg and Ursing	1985	All women in study who had abortions because of fetal malformation experienced severe psychological trauma and about half suffered long-term inability to cope with their personal crises.
Lloyd and Laurence	1985	A retrospective study of 48 women who had abortions for fetal malformation revealed 77% experienced an acute grief reaction with 46% suffering psychiatric symptoms six months post abortion.
Reardon	1986	Of 230 women studied, majority felt "forced" to have abortion; 83% felt "rushed" to make decision; 71% believed their abortion counselors were biased; 80% suffered chronic negative psychological sequelae; 19% reported suicidal ideation; and 20% reported chemical dependencies.
Selby	1986	Study of 92 women who had past abortions who were treated on an in-patient basis revealed majority had been sexually abused in their past; post-abortion delayed reaction common; denial and depression experienced by most women; most had sexual adjustment issues and had experienced termination of primary relationship. Case studies identified post-abortion trauma and unresolved grieving such as

TABLE 2—Continued

Researcher(s)	Date	Major Findings
		denial, anger, bargaining, depression and guilt/shame.
Speckhard	1986	Found abortion a stressor event for most women interviewed and that delayed psychological complications occurred for most of the women studied 5-10 years post abortion. 85% were surprised by the intensity of their negative emotional reactions. 81% felt victimized by their abortions.
Wall	1986	Examined 34 women post abortion. Majority reported chronic emotional problems in the abortion aftermath, including guilt, depression, alcohol and drug abuse, difficulty in relationships, and anxiety in subsequent pregnancies. 26% reported making some suicidal gesture since their abortion.
Hittner	1987	Of 217 women studied, 30% reported one previous abortion. Women with children are more likely to be negatively affected by abortion. Delayed grief was found and nearly 1/3 reported post-abortion unhappiness. "The findings of this study should indicate to mental health counselors that women who choose to have an abortion are more likely to be depressed and lonely than are those in the general population, both before and imme-

TABLE 2—Continued

Researcher(s)	Date	Major Findings
		diately after the procedure. These findings raise questions about the beliefs that only a few women experience post-abortion emotional difficulties."
Lyons, Larson, Huckeba, Rogers and Mueller	1988	A systematic review of research on post-abortion psychological sequelae concluded that all studies suffer from significant methodological shortcomings but did reveal numerous studies showing negative psychological effects of abortion.
Ney	1988	A survey of psychosocial effects of abortion revealed no psychiatric indications for therapeutic abortions. Short and long term medical and psychiatric complications to abortion illustrate harmful effects of elective abortions.

TABLE 3

Adverse Familial Effects of Induced Abortion

Researcher(s)	Date	Major Findings
Calef	1972	Clinical study suggests post-abortion anxiety and disruption of marital sexual relations.
Perez-Reyes and Falk	1973	15% of post-abortion adolescents expressed adverse feelings of depression, guilt, anger and anxiety, some of which were related to family tensions.
Cavenar, Maltbie and Sullivan	1978	Described psychiatric sequelae of abortion in potential grandparents, intrapsychic conflict in children whose mother aborted a pregnancy known to them, and other family members. Case studies show significant physical and emotional sequelae from therapeutic abortions not attributable to environmental changes or other stresses. Case reports highlight post abortion psychogenic problems for some women for twenty years after the procedure.
Ney	1979	Outline of eight methods of how an increasing rate of abortion is leading to an increasing rate of child abuse. Evidence indicates that post-abortion depression hinders mother-infant bonding in a subsequent pregnancy whereas no evidence indicates elective abortions will reduce prevalence of child abuse.

TABLE 3—Continued

Researcher(s)	Date	Major Findings
Plattner	1979	Nearly half of 150 women who elected abortion ended their relationships with the putative father.
Deutsch	1982	Studied 96 pregnant teenagers. Never-pregnant adolescents manifested significantly higher measures for self-esteem than did first time and repeat abortion subjects. Repeat abortion adolescents showed significantly more signs of instability, personality conflict and sex guilt than the never-pregnant group. Teen aborters were more likely to come from families with father absent, marital conflict, poor patterns of communication, family enmeshment or disengagement, and to have lower self concepts.
Ney	1983	Children who have siblings terminated by abortion may have similar psychological conflicts to those children who survive disasters or illness which kill another sibling. Unresolved guilt, fear of parents, obsession to please parents, latent hostility can all be signs of psychological effects of "abortion survivors."
Furlong and Black	1984	Young children may experience particular difficulties in coping with complex information of genetic indicated abortions and

TABLE 3—Continued

Researcher(s)	Date	Major Findings
		may show negative reactions to parents' distress and maternal absence.
Mattinson	1985	Unable to mourn the loss of the child at the time of the abortion, parents show a delayed grief reaction. It may be mild but persistent, or it may occur in more extreme form many years later when subsequent loss of a different nature triggers repressed grief. Many of the married couples in this clinical report are still troubled by an abortion of many years ago, and were largely unaware at the time of the abortion of the intensity of their feelings and the personal meaning of this death experience.
Rue	1985	Because of the basic inequality between the partners in an abortion decision, future marital skills and communication may be severely handicapped and restricted. "Some men view abortion as a destruction of man's seed—a death event."
Ney	1987	Parents have difficulty bonding with surviving children if the neonatal losses are not mourned appropriately, especially if the loss comes from elective abortion. Counselors must help parents and surviving children go through

TABLE 3—Continued

Researcher(s)	Date	Major Findings
		grieving process for neonatal deaths.
Reardon	1988	Summary of case reports of children from one year up to 21 years old suffering negative effects from mother's induced abortion. Children display fear that mother is "agent of death," hostility and agression toward siblings and peers, feeling neglect, experiencing anorexia, depression and withdrawal if not properly treated.

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AMICUS CURIAE

BRIEF

Supreme Court, U.S.
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JOSEPH F. SPANIOL, JR.
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No. 88-790

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

BERNARD J. TURNOCK, M.D., M.P.H., *et al.*,
Appellants,

v.

RICHARD M. RAGSDALE, M.D., *et al.*,
Appellees.

On Appeal from the United States Court of Appeals for the Seventh Circuit

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BRIEF OF THE UNITED STATES CATHOLIC CONFERENCE AS *AMICUS CURIAE* IN SUPPORT OF APPELLANTS

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39 pp

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF *AMICUS*	1
SUMMARY OF ARGUMENT	3
ARGUMENT	6
I. ABORTION'S WIDESPREAD AVAILABILITY SINCE *ROE v. WADE* HAS DETRIMENTALLY AFFECTED WOMEN'S STATUS AND CONDITION	6
A. The "Privacy Model" Has Isolated Pregnant Women, Exposing Them to Pressures to Abort	7
B. The Problems Associated With Illegal Abortion Are Not Solved by Constitutional Abortion and Additional Problems Are Created	10
1. Maternal Deaths	10
2. Psychological Ramifications	14
II. THE MEDICAL REGULATION ISSUE IN THIS CASE EXEMPLIFIES THE JURISPRUDENTIAL PROBLEMS ENGENDERED BY *ROE v. WADE*	16
A. The Abortion Industry Has Been Exempted From the Traditional Regulation of the Medical Profession	17
1. Patient Counseling	18
2. Facility Licensing	21
B. States' Interests in Health and Medical Standards Are Especially Important to the Unborn Child	23
C. States Must Be Allowed to Protect Women From the Adverse Effects of Abortion	27
CONCLUSION	30

TABLE OF AUTHORITIES

CASES: Page

Akron v. Akron Center for Reproductive Health, 462 U.S. 416 (1983) 17, 27
Barsky v. Board of Regents, 347 U.S. 442 (1954) 5, 17
Bellotti v. Baird (II), 443 U.S. 622 (1979) 20
Bender v. Williamsport Area School Dist., 475 U.S. 534 (1986) 6
Bigelow v. Virginia, 421 U.S. 809 (1975) 17
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Fletcher v. Peck, 10 U.S. (6 Cranch) 87 (1810) 22
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In re Guardianship of Grant, 747 P.2d 445, 109 Wash.2d 545 (1987) 17
Meffert v. Packer, 66 Kan. 710 (1903), *aff'd mem.*, 195 U.S. 625 (1904) 18
Planned Parenthood Ass'n v. Ashcroft, 462 U.S. 476 (1983) 17, 20, 26
Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976) 17, 20
Ragsdale v. Turnock, 841 F.2d 1358 (7th Cir. 1988) ..... *passim*
Roe v. Wade, 410 U.S. 113 (1973) ..... *passim*
Semler v. Board of Dental Examiners, 294 U.S. 608 (1935) 18
Simopoulous v. Virginia, 462 U.S. 506 (1983) 22
Thornburgh v. Amer. College of Obstetricians & Gynecologists, 476 U.S. 747 (1986) ..... *passim*

TABLE OF AUTHORITIES—Continued

Page

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Fla. Stat. Ann. (Professions) § 458.324(2) (West 1989) 19
Fla. Stat. Ann. (Professions) § 458.325 (West 1989) 19
Georgia:
Ga. Code Ann. § 43-34-21(g) (1988) 19
Massachusetts:
Mass. General Laws, XVII, Chap. 123, § 23 (1989) 19
New York:
N.Y. Public Health Law § 2500-a (McKinney 1988) 19
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Page

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Page

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

No. 88-790

BERNARD J. TURNOCK, M.D., M.P.H., *et al.*,
Appellants,

v.

RICHARD M. RAGSDALE, M.D., *et al.*,
Appellees.

On Appeal from the United States Court of Appeals for the Seventh Circuit

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BRIEF OF THE UNITED STATES CATHOLIC CONFERENCE AS *AMICUS CURIAE* IN SUPPORT OF APPELLANTS

INTEREST OF *AMICUS*

All active Catholic Bishops in the United States are members of the United States Catholic Conference ("Conference"), a nonprofit corporation organized under the laws of the District of Columbia. The Conference advocates and promotes the pastoral teachings of the Bishops in such diverse areas as education, family life, health care, social welfare, immigration, civil rights, criminal justice, and the economy. When permitted by court rules and practice, the Conference files briefs as *amicus curiae* in litigation of importance to the Catholic Church and its people throughout the United States. Of the values that the Conference seeks to promote through its participation in litigation, respect for human life is of the highest importance.[1]

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[1] Although such values may have religious or denominational roots, they are shared by many, including those who profess no

The Catholic Church's opposition to abortion rests upon its tradition of respect for the sacredness of all life. In accord with its right and responsibility to act for the preservation and dignity of human life, the Church sponsors and supports numerous initiatives beneficial to women in need, from crisis pregnancy counseling to adoption services, and from pre- and post-natal nutritional and pediatric care to post-abortion reconciliation. These and other social welfare efforts on behalf of the dignity of all women flow from the same respect-life ethic that motivates the Church's support of the defenseless unborn.[2] Special efforts are made to serve women undergoing crisis pregnancies, whether they choose to give birth or to abort.[3] Pregnancies ending in abortion involve not only the death of a child, but serious health risks and spiritual

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religion. The suggestion that legislation restricting abortion "establishes" religion is spurious. *Harris v. McRae*, 448 U.S. 297 (1980). The mere fact that religious organizations advocate particular legislative approaches does not establish religion but exemplifies free expression, a right the Bishops do not surrender by either self-restraint or enforced silence. *Compare Webster v. Reproductive Health Services*, 109 S.Ct. 3040, 3085 (1989) (Stevens, J., dissenting) *with* Bernardin, "The Role of the Religious Leader in the Development of Public Policy," 34 *DePaul L. Rev.* 1 (1984) (address to American Bar Association). *See also* Hentoff, "Bishops Have Rights Too," *Washington Post*, Aug. 20, 1989, at B7.

[2] Sacred Congregation for the Doctrine of the Faith, *Declaration on Abortion* 15 (Nov. 18, 1974): "The movement for the emancipation of women, insofar as it seeks essentially to free them from all unjust discrimination, is on perfectly sound ground. . . . [T]here is a great deal to be done in this regard. . . . [However], all publicly recognized freedom is always limited by the certain rights of others."

[3] "Respect for human life leads individuals and groups to reach out to those with special needs. With the support of the Catholic community, Catholic organizations and agencies will continue to provide services and care to pregnant women, especially to those who would otherwise find it difficult or impossible to obtain high-quality care." National Conference of Catholic Bishops, *Pastoral Plan for Pro-Life Activities: A Reaffirmation* 10 (Nov. 1985).

loss for the mother, who afterwards may require the particular care, consolation and reconciliation that the Church offers.

Through their roles as observers, advocates, and caregivers, the Bishops have come to recognize that this Court's decision in *Roe v. Wade*, 410 U.S. 113 (1973), has effected, not a healthy freedom for women, but an oppressive environment where women are pressured to use the available abortion technology in service of a contemporary ethic—an ethic which proclaims that personal convenience, perfect children, and a comfortable lifestyle are paramount values. This abortion ethic is advanced by the Seventh Circuit's decision declaring unconstitutional a program of medical regulation enacted for the health and welfare of Illinois' citizens. It is because of that decision and the ethic it furthers that the Bishops have submitted this brief *amicus curiae* in support of the appellants.

All parties have consented to the appearance of this *amicus*.

SUMMARY OF ARGUMENT

In 1973, this Court held that its privacy jurisprudence "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." *Roe v. Wade*, 410 U.S. 113, 153 (1973). In order to explain its extension of the constitutional right of privacy to abortion, the Court had to engage in speculation as to how certain perceived medical, social, or psychological "detriments" to a pregnant woman might be alleviated by abortion. *Id.* This nation's experience over the past sixteen years shows that those predictions were unfounded. Widespread abortion has not solved these problems; illegal abortion, maternal mortality, family stress, and similar difficulties continue. In addition, abortion has created its own list of undesirable consequences for women and our society.

One of the most insidious of the detriments engendered by *Roe v. Wade* has been the oppression of women by a contemporary ethic that glorifies abortion as an indispensable component of personal freedom. In actuality, a society that pressures women to have abortions for an increasing variety of discretionary reasons has taken away a large measure of their true independence. Women now find themselves pushed ever more relentlessly, not toward motherhood, but toward the abortion clinics. The highly concentrated abortion industry, of which Dr. Ragsdale is just one example, is being judicially freed from legitimate medical regulation on the one hand, while its activities are encouraged by a self-centered contemporary ethic on the other. No longer free to accept their pregnancies, women are increasingly pressured to choose abortion over life. The result is a loss of respect for women themselves as well as for the unborn lives they carry. Having been promised "freedom of choice" by abortion's supporters, pregnant women instead find themselves poorly served by a judicially contrived concept of "autonomy."

In his concurring opinion in *Roe v. Wade* and *Doe v. Bolton*, 410 U.S. 179 (1973) Justice Douglas discussed the nature of "liberty" as including "*autonomous control over the development and expression of one's intellect, interests, tastes, and personality.*" 410 U.S. at 211 (emphasis in original). This right, the Justice said, is "absolute, permitting of no exceptions." *Id.* No other rights encompassed by his notion of liberty, including the right of privacy, were denominated autonomous, and no other Justice spoke of autonomy in relation to personal liberty or privacy in those first abortion cases. 410 U.S. 113-223. Yet by the time the Court reached its decision in *Thornburgh v. American College of Obstetricians and Gynecologists*, a majority had come to employ the concept of autonomy in direct relation to a woman's decision to abort her child. 476 U.S. 747, 772 (1986). By so doing, the Court has truly caused the pregnant woman to be "isolated in her privacy" from all other legitimate interests of society, of her community, of her family, and of her unborn child—an outcome that *Roe v. Wade* disavowed. 410 U.S. at 159. The result of isolating expectant mothers from the aid and support they need has been to expose them to victimization by an abortion industry that masquerades as operating in their best interests, while in fact it seeks to avoid legitimate state regulation aimed at protecting the health and safety of its patients.

In recent years, medical science and technological advancements have combined to expand the definition of the word "patient." As fetal diagnosis, treatment, and even *in utero* surgery have become almost commonplace, the unborn child has been appropriately included in that definition. As patients, both the unborn child and the mother are entitled to the protection of laws regulating the medical profession. When Illinois sought to ensure high medical standards for all ambulatory surgical clinics within the state, including those performing abortions, the United States Court of Appeals for the Seventh Circuit struck down the regulations as unconstitutional at the request of the abortion providers. This was done despite the state's legitimate authority to license and regulate medical practitioners in the interest of protecting all patients. *Barsky v. Board of Regents*, 347 U.S. 442, 449 (1954). The lower court also acted in total disregard of this Court's teaching that the states have a compelling interest in protecting maternal health, preserving prenatal life, *and* upholding professional standards. *Roe v. Wade*, 410 U.S. at 155. For these reasons, this Court must reconsider its abortion jurisprudence and the collapsing foundation on which it was based.[4]

[4] Although this brief *amicus curiae* does not address the issue of the Seventh Circuit's and this Court's appellate jurisdiction in this case, this *amicus* would note that the existence of a federal constitutional right to abortion is crucial to subject matter jurisdiction in this and every abortion case; therefore, the efficacy of *Roe*

ARGUMENT

I. ABORTION'S WIDESPREAD AVAILABILITY SINCE *ROE v. WADE* HAS DETRIMENTALLY AFFECTED WOMEN'S STATUS AND CONDITION.

The opinion of the Seventh Circuit in the instant case is replete with language revealing that the lower court's most pressing concern is the maximum availability of abortion, which it assumes to be in women's best interests. *Ragsdale v. Turnock*, 841 F.2d 1358, 1370-76 (7th Cir. 1988). Such a notion has roots in *Roe v. Wade*, 410 U.S. 113, 153 (1973). By proceeding in this vein, the Seventh Circuit, like many other courts rendering post-*Roe* abortion decisions, missed an opportunity to preserve and promote women's genuine interests. Women are burdened not by laws seeking to ensure the safety of abortive procedures, such as those enacted by Illinois, but by the underlying tragedy inherent in abortion's widespread availability.

In the ensuing years since this Court's decision in *Roe* guaranteed abortion virtually on demand,[5] abortion's deleterious effects upon respect for all life, including women's lives, have become quite apparent. Ironically, the Court's focus upon protecting the abortion "right" has led to decisions actually compromising women's best interests.[6] In light of these unanticipated results, it is time

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v. Wade, under which the federal question is presented, is always at issue in abortion cases, whether raised by a party or not. *See Bender v. Williamsport Area School Dist.*, 475 U.S. 534, 541, 547 (1986).

[5] *Thornburgh v. Amer. College of Obstetricians and Gynecologists*, 476 U.S. 747, 783-84 (1986) (Burger, C.J., dissenting).

[6] *See, e.g., Thornburgh*, 476 U.S. at 799 (1986) (Rehnquist and White, JJ., dissenting) ("One searches the majority's opinion in vain for a convincing reason why the apparently laudable policy of promoting informed consent becomes unconstitutional when the subject is abortion."); *see also Ragsdale v. Turnock*, 841 F.2d at 1389 (Coffey, J., dissenting) ("It defies reason to allow the state

that this Court do what it proposed in *Doe v. Bolton*, 410 U.S. 179, 191 (1973) and "readjust its views and emphases in light of the advanced knowledge and techniques of the day."[7] Such a readjustment was broached in *Webster v. Reproductive Health Services*, 109 S.Ct. 3040 (1989). This case allows the Court another chance to examine the ways in which its abortion jurisprudence has developed upon assumptions now proven false. One of these erroneous assumptions was that maximizing privacy would not isolate women from the support and understanding needed at times of crisis.

A. The "Privacy Model" Has Isolated Pregnant Women Exposing Them to Pressures to Abort.

The argument that women's lives are improved by increasing abortion's availability—a claim accepted in *Roe* and by the Seventh Circuit in the instant case—ignores abortion's actual consequences for women's "freedom of choice." It is precisely the prevalence of abortion, with its attendant principle of unlimited autonomy,[8] that has

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to license an ASTC performing hernia surgery, cataract removals, and repairs of a torn or detached retina, but not permit the state to license ASTCs primarily performing abortions when there are many similar risks involved in the myriad types of abortive procedures.").

[7] This Court placed a freedom to choose abortion within its privacy doctrine in part because it thought that constitutionalizing abortion would serve the health and welfare of both women and society. *Roe v. Wade*, 410 U.S. at 153. But abortion has failed to solve the medical, familial and societal problems it was supposed to cure and, instead, has worsened the condition of women, the family, our communities and the nation. Brief *Amicus Curiae* of U.S. Catholic Conference in *Webster v. Reproductive Health Services*, No. 88-605. In the process, the Court has exposed *Roe*'s internal illogic and flaws to intense criticism. *E.g.*, Wardle, "Rethinking Roe v. Wade," 1985 *B.Y.U. L. Rev.* 231.

[8] A majority of this Court first endorsed the concept of a woman's "autonomy" in choosing abortion in the *Thornburgh* case. 476 U.S. at 772. Autonomy comes from the Greek words *autos*, meaning self, and *nom(os)*, meaning law; literally then autonomous

led to a social ethic and atmosphere which virtually compels a woman to favor abortion if having a child might cause her, the father, or her family some present inconvenience. As one feminist author has observed, unlimited autonomy is deceptive and even burdensome:

> In gaining the choice to control the quality of our children, we may rapidly lose the choice *not* to control the quality, the choice of simply accepting them as they are. The new reproductive technology is offered to us in terms of expanding choices. But it is always true that while new technology opens up some choices, *it closes down others.*

B. Rothman, *The Tentative Pregnancy* 11 (1986) (emphasis added). Recent statistics reveal how this abortion ethic discourages choosing to give birth.

In 1988, the Alan Guttmacher Institute reported that the overwhelming majority of women abort for discretionary, social reasons unrelated to health problems. Approximately 76% of the women interviewed cited worries about how a baby could interfere with work, school or other responsibilities; 50% said they did not want single parenthood or had relationship problems; 31% said they were not ready for the responsibility; and 13% said the fetus had a possible health problem. Of the 7% citing their own health problems, only half said a doctor told them their condition might be made worse by remaining pregnant. Torres & Forrest, "Why do Women Have Abortions?" 20 *Family Planning Perspectives* 169-76, 170 (1988). In fact, women are often pressured by the father,[9] by their families, and finally by the abortion

means: a law unto one's self. This is a wholly inappropriate term to apply to the decision to abort—a decision that affects the father, the family, the community, our society, and the unborn child.

[9] Twenty-three per cent of the participants in the 1988 Alan Guttmacher Institute survey said that their husband or partner wanted the abortion. Torres & Forrest, "Why do Women Have Abortions?" at 170.

industry [10] to be, not the authors, but the terminators of life. Following abortion, they face the most intimate physical and psychological scars left by their action. The right touted as a preserver of women's freedom has thus become a vehicle for their oppression.[11]

This Court explicitly recognized in *Roe* that in the abortion context, a woman "cannot be isolated in her privacy." 410 U.S. at 159. But abortion jurisprudence *has* isolated women, exposing them to the one-sided pro-abortion message of "freedom," while failing to acknowledge or afford protection from abortion's ill effects. Perhaps the primary example of this dynamic is *Thornburgh* where, in the name of women's "freedom of choice" and "autonomy" (476 U.S. at 759, 772), the majority declined to allow women considering abortion to hear of its "det-

[10] There exists a highly concentrated abortion industry in the United States. In 1985, only 21 percent of all non-Catholic general short-term hospitals and 17 percent of public hospitals provided any abortion services. Thirty-eight hospitals and 461 clinics, representing 19 percent of all providers of abortion services, accounted for 77 percent of all legal abortions. Tietze, Forrest & Henshaw, "United States of America," in *International Handbook on Abortion* 476-77 (Sachdev ed. 1988). Dr. Ragsdale's current situation reflects the national model. He performs approximately five percent of all the abortions performed annually in Illinois, or about 3400-3500 per year. His potential annual gross income from abortions alone is approximately $875,000.00. *Ragsdale v. Turnock*, 841 F.2d at 1392 (Coffey, J., dissenting).

[11] Evidence of the frequency with which women are pressured toward abortion appears in Carol Gilligan's *In a Different Voice* 80-127 (1982), a work intended only as an exploration of women's moral development, but comprised of the results of interviews with women prior to and after abortion decisions. Out of eleven women whose interviews are recounted at length, eight recount stories of coercion. The stories provide striking testimony that women are made to feel selfish by persons close to them if they think seriously about giving birth to the child, since this may cause increased financial obligations, the need for the parents' increased commitment to each other and to the well-being of another, or impediments to already laid employment, career, or educational plans.

rimental physical and psychological effects" and "particular medical risks" because these might deter a choice for abortion. 476 U.S. at 764. Said the Court: "The decision to terminate a pregnancy is an intensely private one. . . ." 476 U.S. at 766. This grant of privacy was then misused, denying women access to the balanced medical opinion necessary for carefully considering abortion's harmful effects upon themselves and others. This "privacy model" of abortion rights, begun in *Roe v. Wade*, has proved inimical to any real recognition of coexisting rights, while effectively isolating women, not only from their unborn children and their families, but from the information necessary for them to make their own decisions. Those who most need the information never hear about the adverse physical and psychological effects of choosing abortion over life.

B. The Problems Associated With Illegal Abortion Are Not Solved by Constitutional Abortion and Additional Problems Are Created.

When the majority in *Roe v. Wade* speculated that constitutional abortion would ease mental stress, decrease maternal deaths, and eliminate illegal abortions (410 U.S. at 153), it simply ignored the potential detriments to women, their families, and society from an ever increasing number of abortions. Tragically the detriments have come to pass, while the supposed benefits remain unrealized.

1. *Maternal Deaths.*

Legalized abortion has not eliminated maternal deaths or illegal abortions. Prior to *Roe v. Wade*, abortion advocates inflated the estimates of illegal abortions and maternal deaths in order to influence judges and legislators.[12] Researchers have more recently determined that

[12] Estimates of illegal abortions prior to *Roe v. Wade* have proven notoriously unreliable. *Abortion in the United States* 180 (D. Calderone ed. 1978); Tietze, "Induced Abortion as a Method of Fertility Control," in *Fertility And Family Planning: A World View* 311 (S.J. Berman, *et al.* eds. 1969); B. Nathanson, *Aborting America* 193 (1979).

legal abortion does not replace illegal abortion; rather, total abortions have increased six- to eleven-fold.[13] Not only do deaths from illegal abortions continue to occur,[14] but constitutional abortion has added its own casualties to the maternal mortality statistics—in some cases simply bringing "back-alley" practitioners to the clinics.[15] In-

[13] Syska, Hilgers & O'Hare, "An Objective Model for Estimating Criminal Abortions and Its Implications for Public Policy," in *New Perspectives on Human Abortion* 164-81, 178 (Hilgers, Horan & Mall eds. 1981). Earliest estimates that legal abortions simply replace illegal ones assumed that unintended pregnancies remain constant despite easier access to abortions—an assumption now proven false. *See* K. Luker, *Taking Chances: Abortion and the Decision not to Contracept* (1975). *See also*, Tietze, Forrest & Henshaw, "United States of America," in *International Handbook on Abortion* at 476, where the authors estimate that of the approximately 1.6 million abortions occurring per year in the United States since 1985, from 600,000 to 1.1 million have replaced not illegal abortions but "unwanted" births.

[14] Hilgers & O'Hare, "Abortion Related Maternal Mortality: An In-Depth Analysis," in *New Perspectives* 69-91. Supporters of abortion now admit that "a substantial proportion of illegal abortions in the 1960s were performed by physicians, including some highly experienced practitioners, while in the late 1970s, most illegal abortions were self-induced or performed by medically unqualified practitioners. It is entirely possible that the death-to-case ratio following illegal abortion in the United States is now higher, not lower, than it was 15-20 years ago." Tietze & Henshaw, *Induced Abortion: A World Review 1986* 132 (Alan Guttmacher Institute 1986).

[15] In 1978 independent investigators uncovered twelve previously unreported deaths and other gross abuses in Chicago-area abortion clinics. Zekman & Warrick, "The Abortion Profiteers," *Chicago Sun-Times*, Dec. 3, 1978 (special reprint). In response, Edward F. King, Deputy Director of the Chicago Health Society, explained to the press: "The Courts very effectively knocked the Department of Health out of the picture. We're not even entitled to cross the

deed exhaustive study has shown that maternal deaths resulting from legal abortions are replacing those due to illegal abortions. Hilgers & O'Hare, "Abortion Related Maternal Mortality," *supra* note 14, at 90. The trend toward a decrease in maternal deaths due to abortion began before *Roe v. Wade* and is attributable to improvements in health care and obstetrical medicine, not constitutional litigation. J. Legge, *Abortion Policy: An Evaluation of the Consequences for Maternal and Infant Health* 154-55 (1985).[16] Recent evidence suggests that "in competition with other factors, [*Roe v. Wade*] and its implementation did not have a strong impact on health indicators." *Id.* at 150. After 1973 the decline in abortion-related deaths stopped and reversed itself in 1977,

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threshold of these clinics." Brodt & McCabe, "Abortion Investigation Set," *Chicago Tribune*, Nov. 13, 1978, at A1. *See, e.g., Friendship Medical Center v. Chicago Board of Health*, 505 F.2d 1141, (7th Cir. 1974), *cert. denied*, 420 U.S. 997 (1975). Concluded one of the investigative reporters on the case, Pamela Zekman: "In 1973 the Supreme Court legalized abortion. As it turns out, what they legalized in some clinics in Chicago is a highly profitable and very dangerous back-room abortion." "Risky Abortions: Chicago clinics are exposed," *Time Magazine* 52 (Nov. 27, 1978).

[16] Maternal mortality from all causes has declined sharply since the 1940s due to antibiotics and other medical advances. Beginning in 1965, abortion-related deaths decreased faster than other maternal deaths, in part because "illegal abortions may have shifted from the non-medical to the medical sector and become safer." Cates, U.S. Centers for Disease Control, Statement Submitted to the U.S. Senate Judiciary Subcommittee on the Constitution, in 2 *Constitutional Amendments Relating to Abortion* 439 (U.S. GPO Serial No. J-97-62) (1983). An international comparison by abortion supporters recently concluded that "reported rates of abortion mortality are more closely associated with the availability of modern methods of contraception (including surgical sterilization), with the general level of health services and with the adequacy of the registration system than with the legal status of abortion or the presumed incidence of illegal abortions performed by untrained operators." Tietze & Henshaw, *Induced Abortion: A World Review 1986*, *supra* note 14, at 127.

1979, and 1982. U.S. Centers for Disease Control, *CDC Surveillance Summaries* 955 (1986).[17]

This country's experience after the adoption of the "Hyde Amendment" by Congress in 1976 is particularly instructive on this point.[18] Before the Hyde Amendment became effective, abortion advocates predicted increases in illegal abortions and maternal deaths.[19] When the federal funding cut occurred, legal abortions among Medicaid-eligible women declined but there was no discernible evidence of resort to illegal abortions or of increased abortion-related mortality.[20] In addition, more intensive investigation did not find the predicted maternal deaths and complications. Over an eighteen-month period, investigators could attribute only one death of a Medicaid-eligible woman to the funding cut but even this was ulti-

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[17] In 1977 alone, over 100,000 women sustained abortion complications and 16 died. U.S. Centers for Disease Control, 1979, reprinted in Grimes & Cates, "Abortion: Methods and Complications," in *Human Reproduction: Conception and Contraception* 796 (E.S.E. Hafez 2nd ed. 1980).

[18] The Hyde Amendment, named for its principal sponsor, prohibits the use of federal Medicaid funds to pay for abortion except under certain specified circumstances. *See Harris v. McRae*, 448 U.S. 297, 302 (1980).

[19] *E.g.*, Berger, M.D., "Abortion in America: The Effects of Restrictive Funding," 298 *New Eng. J. Med.* 1474-77, 1475 (June 29, 1978); *see* Pettiti & Cates, "Restricting Medicaid funds for abortions: projections of excess mortality for women of childbearing age," 67 *Am. J. of Public Health* 860-62 (1977).

[20] "Original projections by the CDC that the cutoff of medicaid funding for abortions would result in 5-90 excess abortion-related deaths annually have not proved true." "No Excess Deaths Follow Medicaid Cutoff of Abortion," *Ob. Gyn. News* (April 1, 1979) (statement of Dr. Willard Cates); *see also* U.S. Centers for Disease Control, 29 *Morbidity and Mortality Weekly Reports* 254 (June 6, 1980); Trussel, *et al.*, "The Impact of Restricting Medicaid Financing for Abortion," 12 *Family Planning Perspectives* 120-30, 127, 128 (May/June 1980).

mately found to be due to other factors.[21] Such actual experience demonstrates that restricting abortion does not create the threat to maternal health popularly portrayed, but abortion itself does.

2. *Psychological Ramifications.*

Several concerns that prompted this Court to protect abortion as a privacy right dealt with the psychological stress that pregnancy and child care may place upon the mother and her family. 410 U.S. at 153.[22] The underlying assumption was that abortion would relieve the psychological burden and, presumably, not replace it with something worse. Experience proves otherwise.

Only five years after *Roe v. Wade*, the psychological evidence against abortion had accumulated to the point that experts could conclude that "[a]bortion puts women at greater risk mentally" than does childbirth. *The Psychological Aspects of Abortion* x. (Mall & Watts eds. 1979). "Out of the sea of conjecture surrounding the psychological aspects of abortion emerges the somewhat heretical idea that social policy may have moved in the wrong direction." *Id.* at xi. It is now even more clear that abortion policy did take a wrong turn and that women and their families are suffering psychologically as a result. "Not only is the woman who has a genuine psychiatric handicap more likely to suffer than benefit from an abortion, but across the board the prognosis of

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[21] Gold & Cates, "Restriction of Federal Funds for Abortion: 18 Months Later," 69 *Am. J. of Public Health* 929 (Sept. 1979). Reporters discovered that the Texas woman "portrayed as a martyr to the Hyde Amendment" had died for reasons not related to the funding cutoff. Grand & Murray, "Facts Don't Back Link of Abortion Death in Texas to Fund Cutoff," *Ob. Gyn. News* 1, 26 (Dec. 1, 1977).

[22] It is not easy to understand how this concern about the family expressed in *Roe* became a policy treating abortion as an autonomous decision affecting only the mother and her physician. *See, e.g., Thornburgh*, 476 U.S. at 772.

a post-abortive psychosis is worse than that of a post-partum one." Sim, "Abortion and Psychiatry," in *New Perspectives* 151-63, 162; *see also* Liebman & Zimmer, "The Psychological Sequelae Of Abortion: Fact and Fallacy" in *The Psychological Aspects of Abortion* 127-38 (1979); and Rue, "Abortion in Relationship Context," *International Review of Natural Family Planning* 95-121 (Summer 1985).

It is beyond question that post-abortion trauma exists, though few studies have extended over the duration of time necessary to probe women's deepest reaction to their abortions. While it is common for women to express only relief shortly after an abortion, having completed the feared surgical procedure,[23] in the long run, the negative effects of abortion are significantly more visible. One 5-year study found that women who had undergone abortions were more than eight times more likely to seek psychiatric help than other women. Badgley, *et al., Report of the Committee on the Operation of the Abortion Law* 313-21 (Ottowa: Supply and Services 1977).[24]

The increasing use of amniocentesis and other prenatal diagnostic techniques for detecting fetal abnormalities, often as a precursor to abortion, has also exacerbated

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[23] D. Reardon, *Aborted Women: Silent No More* 116 (1987).

[24] "A review of published reports on women who had been denied abortion and were followed up shows that 70.6% of the 6298 women completed their pregnancies and only 13.2% had an abortion elsewhere." These women, denied abortion by review committees in various European countries, could reasonably be expected to have the most negative emotional attitudes toward giving birth. Yet "the literature shows a generally comparable outcome of pregnancy, delivery and puerperium between women who were denied abortion and controls," "no evidence that a continued unwanted pregnancy will endanger the mother's mental health," and "good acceptance of the infant by the mother, especially if she has the father's support." Del Campo, M.D., F.R.C.S., "Abortion denied—outcome of mothers and babies," 130 *J. of the Canadian Med. Ass'n* 361, 362 (1984).

psychological problems by eroding parents' willingness to accept the children they have voluntarily conceived. This practice at least delays, and may disrupt, the vital development of maternal-infant bonding. B. Rothman, *The Tentative Pregnancy* 100-102 (1986). This problem is likely to increase as more women resort to, or are pressured into, prenatal diagnosis and abortion for reasons of convenience, such as to select a child of the desired sex.[25] And the total number of such abortions is increasing- just as some courts, including the Seventh Circuit, are making it more difficult for states to regulate the abortion industry in the interest of women's health and safety.

II. THE MEDICAL REGULATION ISSUE IN THIS CASE EXEMPLIFIES THE JURISPRUDENTIAL PROBLEMS ENGENDERED BY *ROE v. WADE*.

In the area of abortion jurisprudence, it is sometimes possible to lose track of important facts absent frequent reminders. One basic fact, too often overlooked, was highlighted by Circuit Judge Coffey in his dissent below:

> [T]he most significant undisputed fact in the record is that an abortion, regardless of the trimester in which it is performed, is considered a surgical procedure, albeit a minor surgical procedure, accompanied all too frequently by concomitant medical, physical, and psychological complications.

841 F.2d at 1376 n.2 (Coffey, J., dissenting). Labelled a surgical procedure, abortion falls within the ambit of the states' authority to regulate in the interests of health and safety *and* in maintaining medical standards generally. *Roe v. Wade*, 410 U.S. at 155.

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[25] Since amniocentesis can now be used to determine an unborn child's gender with certainty, abortions of children not of the desired sex are increasing. Jancin, "Prenatal Gender Selection Appears to be Gaining Acceptance," 23 *Ob. Gyn. News* 1, 30-31 (Mar. 1-14, 1988). *See* Kolata, "Fetal Sex Test Used as Step to Abortion," *The New York Times*, Dec. 25, 1988, at A1, A38.

In part the interest in ensuring high standards for the medical profession serves the state's interest in safeguarding maternal health. *See, e.g., Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 428-29 (assuming without discussion some relation of the two interests); *Roe v. Wade*, 410 U.S. at 163. The maintenance of medical standards is also related to the state's interest in protecting the unborn child. *See Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476, 486 (1983) (upholding second physician requirement). But beyond these aspects, the interest in regulation of the medical profession generally justifies reasonable supervision of the physician-patient relationship throughout pregnancy to assure that professional standards remain consistently high.[26] *See, e.g., Connecticut v. Menillo*, 423 U.S. 9, 11 (1975) (*per curiam*) (upholding physician licensing requirements); *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 67 (1976) (upholding informed consent requirement); *see also Akron*, 462 U.S. at 460 and nn. 6 & 7 (O'Connor, J., dissenting).

A. The Abortion Industry Has Been Exempted From the Traditional Regulation of the Medical Profession.

Although this Court has called the abortion decision "in all its aspects . . . a medical decision" (410 U.S. at 166), it simply has not enforced the state's interest in

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[26] The authority of a state to license and regulate the practice of medicine is a "vital part of a state's police power." *Barsky v. Board of Regents*, 347 U.S. 442, 449. *See Bigelow v. Virginia*, 421 U.S. 809, 827 (1975). A licensed physician has no right to practice medicine according to his own unfettered judgment but rather is subject to reasonably exercised but extensive authority. *Whalen v. Roe*, 429 U.S. 589, 604 (1977); *see Friedman v. Rogers*, 440 U.S. 1, 9-10 (1979) (Powell, J.) (first amendment interest in medical service name). *See also Brophy v. New England Sinai Hospital*, 398 Mass. 417, 497 N.E.2d 626 (1986); *In re Guardianship of Grant*, 747 P.2d 445, 109 Wash.2d 545 (1987) and cases cited therein (states' interest in the integrity of the medical profession).

maintaining professional standards where abortion is concerned. *See Thornburgh*, 476 U.S. at 802-4 (White, J., dissenting). In decrying the majority's abandonment of medical standards, Justice White calls the reasoning "nonsensical." *Id.* at 802. "I had thought it clear," the Justice continues, "that regulation of the practice of medicine, like regulation of other professions . . ., was a matter peculiarly within the competence of legislatures . . . ." *Id.*; *see also id.* at 783 (Burger, C.J., dissenting). And indeed, before *Roe v. Wade* threw into doubt constitutional principles previously espoused by this Court (*Id.* at 814 (O'Connor, J., dissenting)), regulation of the medical profession in the interest of public welfare was not only a legislative prerogative but a public duty. *See generally Semler v. Board of Dental Examiners*, 294 U.S. 608, 612 (1935).

1. ***Patient Counseling.***

One classic application of the state's regulatory authority over the medical profession has always been the protection of a citizen's right to be informed before consenting to any surgical procedure. *Dent v. West Virginia*, 129 U.S. 114, 122 (1889):

> The power of the state to provide for the general welfare of its people authorizes it to prescribe all such regulations as, in its judgment, will secure or tend to secure them against the consequences of ignorance and incapacity as well as deception and fraud.

Accord Meffert v. Packer, 66 Kan. 710, 714 (1903), *aff'd mem.*, 195 U.S. 625 (1904). The denial of adequate information ultimately works to the detriment of the patient. Although the physician has the discretion to decide that certain information need not be provided if it is "infeasible or contraindicated from a medical point of view," the privilege of nondisclosure is "severely circumscribed" so that the exception does not devour the rule. *Canterbury v. Spence*, 464 F.2d 772, 788 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). "The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs." *Id.*

Consistent with this Court's decision in *Virginia Board of Pharmacy v. Virginia Citizens Consumer Council*, 425 U.S. 748, 750-51, 765 (1976), when state legislatures have found that the medical community is not providing minimally adequate information to patients, they have not hesitated to act. For example, New York requires that information be provided to pregnant women about the potential adverse impact of medication to be used during pregnancy and delivery,[27] and to parents about metabolic disorder in their newborns.[28] Florida has enacted legislation designed to guard against too frequent use of electroconvulsive (shock) therapy by adding new consent requirements.[29] Several states have enacted laws requiring that victims of breast cancer give adequately informed consent after physicians provide oral or written summaries of the various alternatives prior to assent to any particular procedure.[30] These examples are measures that affect directly the physician-patient relation-

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[27] N.Y. Public Health Law § 2503 (McKinney 1988). This gives the woman the right to decline certain medications, or at least knowingly assent to their use.

[28] *Id.* § 2500-a.

[29] Fla. Stat. Ann. (Professions) § 458.325 (West 1989).

[30] Ga. Code Ann. § 43-34-21(g) (1988); Fla. Stat. Ann. (Professions) § 458.324(2) (West 1989). These examples are but a few of those that may be found in state statutes. *See, e.g.*, N.Y. Public Health Law § 2505 (McKinney 1988) (requiring information about infant nutrition and breast-feeding); Mass. General Laws, XVII, Chap. 123, § 23 (1989) (regarding informed consent by mental patients to shock treatment or lobotomy).

ship at its most elemental level by shaping the content of their dialogue.

When Illinois acted to adopt the counseling provisions struck down by the lower courts, it was similarly well within the authority traditionally accorded the states in this area.[31] Even the lower court admitted that the Illinois provisions were "not as intrusive or specific" as those declared unconstitutional in *Thornburgh*. 841 F.2d at 1373. In *Akron* this Court found unobjectionable certain information relevant to an informed choice, *i.e.*, the status of one's pregnancy, the availability of community and other resources, the existence and efficacy of alternatives to abortion and public assistance, and the particular risks and benefits of options available to the woman. *Akron*, 462 U.S. at 445-46 n.37. Yet this is precisely the nature of the counseling that the Seventh Circuit found "inflexible" and declared unconstitutional. 841 F.2d at 1373.[32]

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[31] Former Justice Powell has cited "The Abortion Profiteers," *Chicago Sun-Times* (1978), the Pulitzer Prize-winning series that exposed numerous abuses and manipulation of women seeking help with a pregnancy in Illinois. *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. at 488 & n.12; *see* note 15, *supra*. Clearly, faced with such information, the State has an obligation to ensure that minimally adequate information is transmitted to a woman before she consents to an abortion.

[32] As for Illinois' requirement that abortion counselors who provide this information have no financial interest in the operation, it is frankly inconceivable that the majority of the Seventh Circuit could not distinguish between a "physician" and a "counselor," as those terms are used in the applicable section of the statute. *Compare* A.S.T.C. § 205.730(a)(2) *with* (b)(2). 841 F.2d at 1401. Abortion clinic personnel, with an economic interest at stake, would not likely offer balanced "counsel and support." *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. at 91 (Stewart, J., concurring). As the plurality warned in *Bellotti v. Baird* (II), 443 U.S. 622, 642 n.21 (1979): "Many minors who bypass their parents probably will resort to an abortion clinic, without being able to distinguish the competent and ethical from those that are incompetent and unethical."

2. ***Facility Licensing.***

The court below not only declared Illinois' licensing requirements unconstitutional, but on the strength of that finding alone, proclaimed the collapse of the State's entire regulatory program. 841 F.2d at 1371. Yet even in *Roe v. Wade* this Court anticipated, even invited, the licensing of physicians and their facilities:

> Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other places of less-than-hospital status; as to the licensing of the facility; and the like.

410 U.S. at 163. In *Connecticut v. Menillo*, 423 U.S. at 11, this Court held that licensing requirements imposed on persons performing abortions in the first trimester of pregnancy infringed no privacy interest. "[A]fter the first trimester, the ever increasing state interest in maternal health provides additional justification. . . ." *Id.* (emphasis added). In light of *Webster*, 109 S.Ct. at 3056-57, such an artificial limitation cannot be justified. Indeed, Chief Justice Rehnquist's comparison of the trimester framework to a Procrustean bed is particularly apt in this case. 109 S.Ct. at 3056. The Seventh Circuit took a statutory scheme aimed at licensing and regulating ambulatory surgical centers generally and tried to force it into abortion's trimester bed. When the court, like Procrustes, found that it did not fit, it began cutting off limbs until the whole body of regulation was declared dead. In assessing the constitutionality of a state's efforts

to protect the health and safety of the citizens, such a crude approach is wholly inappropriate.[33]

More proper is the approach taken by Justice O'Connor when she stated in *Akron* that the state's interests in health, medical standards, and human life "are present *throughout pregnancy.*" 462 U.S. at 459 (O'Connor, J., dissenting) (emphasis in original). *See also Webster*, 109 S.Ct. at 3057. Considered in this way, the regulatory program enacted by Illinois is well within its *"considerable discretion* in determining standards for the licensing of medical facilities." *Simopoulous v. Virginia*, 462 U.S. 506, 515 (1983) (emphasis added). The court below effectively conceded the breadth of state regulatory discretion when it acknowledged that Illinois' regulatory scheme would be upheld if applicable only to second and third trimester abortions. 841 F.2d at 1368, 1369 & n.8. In choosing the standard for judging first trimester abortions, however, the lower court rejected consideration of the fact that the regulations applied to all ambulatory surgical facilities. As this Court noted in *Ashcroft*, the broad application of a requirement strengthens its validity. 462 U.S. at 486, 488. Suggesting further that care required of hospitals may also be appropriate to outpatient clinics, this Court stated that "there may be good reason to impose stricter standards in this respect on clinics performing abortions than on hospitals." *Id.*

Sixteen years' experience under *Roe v. Wade* has given this country such "good reason." Today we face an impersonal and profiteering abortion industry where a practitioner like Dr. Ragsdale methodically aborts 3,500 babies each year, year after year, with little or no professional regulation. 841 F.2d at 1391 (Coffey, J., dissenting). When the states, like Illinois, attempt to en-

[33] "The question, whether a law be void for its repugnancy to the constitution, is, at all times, a question of much delicacy, which ought seldom, if ever to be decided in the affirmative in a doubtful case." *Fletcher v. Peck*, 10 U.S. (6 Cranch) 87, 128 (1810).

force comprehensive medical standards applicable to other surgical procedures against such practitioners, their efforts are routinely thwarted by the courts.[34]

B. States' Interests in Health and Medical Standards Are Especially Important to the Unborn Child.

Another "good reason" to impose strict standards on abortion clinics is the same good reason that justifies strict regulation of abortion generally—the interests of the unborn child. Although *Roe v. Wade* held out the prospect of a compelling state interest in prenatal life (410 U.S. at 163), *Webster* finally offered realistic support for that concern (109 S.Ct. at 3057). Throughout the decisions of this and other courts, this compelling interest has been recognized in varying degrees and differing language.[35] In recent years, however, there has been a new term applied to the unborn child—a term that comes from outside the abortion debate and with which none of the advocates can legitimately disagree. That term is *patient. Williams Obstetrics* vii (J. Pritchard & P. MacDonald 16th ed. 1980).

[34] Indeed, in its enthusiasm to relieve appellee of all state regulation, the Seventh Circuit admittedly invalidated legitimate statutory provisions. 841 F.2d at 1372 n.11, 1375. Thus did the court lend further proof to Justice O'Connor's prediction that "no legal rule or doctrine is safe from ad hoc nullification . . . when an occasion for its application arises in a case involving state regulation of *abortion.*" *Thornburgh*, 476 U.S. at 814 (O'Connor, J., dissenting).

[35] The uses of different terminology by judges and advocates on all sides of the abortion debate is itself a juridical phenomenon. All engaged in these cases have, consciously or unconsciously, adopted the theory that control of the language determines the outcome of the matter. One of the most misleading labels found in the cases is the adjective "potential" as applied after conception. Prior to conception, the phrase "potential human life" *might* have some logical relevance when referring to the ovum and the sperm. At conception, however, that potential has been realized. Life exists, and it can only be human. The debate may rage over whether it is a fetus or a baby, but actual life, fully capable of further development, clearly exists.

In the 1980's, both the scientific literature [36] and the popular press [37] have heralded the latest medical advances in the field of *in utero* diagnosis and treatment. The technology that has led the way to many of these advances is ultrasonography.[38] Using ultrasound signals, physicians are able to scan the womb, producing a sonogram or television-like live image of the child in the womb.[39] With ever-increasing refinements in technique and equipment, they can visually diagnose the baby's condition and, if necessary, perform highly delicate surgical and other

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[36] *See, e.g.*, Daffos, M.D., *et al.*, "Prenatal Management of 746 Pregnancies At Risk for Congenital Taxoplasmosis," 318 *New Eng. J. Med.* 271 (Feb. 4, 1988); *Neonatal-Perinatal Medcine: Diseases of the Fetus and Infant* (A. Fanaroff & R. Martin 4th ed. 1987); B. Spirt, L. Gordon & M. Olipant, *Prenatal Ultrasound: A Color Atlas With Anatomic and Pathologic Correlation* (1987); Clewell, *et al.*, "A Surgical Approach To The Treatment of Fetal Hydrocephalus," 306 *New Eng. J. Med.* 1320 (June 3, 1982); Dillon, M.D., *et al.*, "Life Support and Maternal Brain Death During Pregnancy," 248 *J. Amer. Med. Ass'n* 1089 (Sept. 3, 1982).

[37] *See, e.g.*, Henig, "Saving Babies Before Birth," *The New York Times*, Feb. 26, 1982, at 18 (Magazine).

[38] One unexpected but welcome byproduct of the sonogram is its tendency to promote parental bonding with the prenatal child, even in the earliest stages of pregancy. Fletcher & Evans, "Sounding Boards: Maternal Bonding in Early Fetal Ultrasound Examinations," 308 *New Eng. J. Med.* 392 (Feb. 17, 1983). Once they have seen the living human being inside themselves, some mothers immediately forego thoughts of abortion. *Id.* For this very reason, some abortion supporters openly advise against allowing the mother to see the baby's image for fear she will be discouraged about having an abortion. "Warns of Negative Psychological Impact of Sonography in Abortion" *Ob. Gyn. News* (Feb. 15-28, 1986). Those who advise this course clearly place a higher priority on maximizing abortions than on "freedom of choice." *See* Arguments I.A. and I.B.2., *supra*.

[39] Chervenak, M.D., *et al.*, "Current Concepts: Advances in the Diagnosis of Fetal Defects," 315 *New Eng. J. Med.* 305 (July 31, 1986).

procedures.[40] Not only are the infant's external features discernible, but internal organs, heartbeat and blood flow can be examined, and gestational age may be determined.[41]

After diagnosis of fetal diseases or defects, innovative treatments now mean that conditions which previously could have proved crippling or fatal to the newborn infant are being treated before birth.[42] Babies delivered prematurely, with extremely low birthweight, are being saved by new high-technology therapy.[43] Maternal behavior and environmental conditions that can affect the development of the unborn child are being studied and treated.[44] Fetal surgery is increasing.[45] Such medical achievements have caused at least one avowed abortion supporter to admit that "the same skills that can be used to rescue extremely premature newborns can be brought to bear in these cases [saving aborted fetuses]." [46] Thus

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[40] *Id.* at 305-6.

[41] *Id.* at 306.

[42] Kolata, "Fetuses Treated Through Umbilical Cords," *The New York Times*, Mar. 29, 1988, at C3.

[43] Callahan, "How Technology is Reframing the Abortion Debate," *Hastings Center Report* 33-34 (Feb. 1986).

[44] *Id.* at 36.

[45] "Occasional Notes: Fetal Treatment 1982," 307 *New Eng. J. Med.* 1651 (Dec. 23, 1982); "Medical Progress: Pediatric Surgery," 319 *New Eng. J. Med.* 94 (July 14, 1988). *See also* Blakeslee, "Fetus Returned To Womb Following Surgery," *The New York Times*, Oct. 7, 1986, at C1.

[46] Callahan, "How Technology is Reframing the Abortion Debate," *supra* note 43, at 35. The author then raises the question of whether a woman who chooses to abort is entitled only to the end of pregnancy or to a dead fetus. *See Wynn v. Scott*, 449 F. Supp. 1302, 1321 (N.D. Ill. 1978) ("It never could be argued that she has a constitutionally protected right to kill the fetus."), *appeal dismissed, Carey v. Wynn*, 439 U.S. 8 (1978), *aff'd*, 599 F.2d 193 (7th Cir. 1979).

medical science has reached a point where the fetus is a patient for all purposes, not only *in utero* but post-abortion as well. This medical realization coincides with the proper legal recognition of the unborn child's unique status.

In the oft-quoted passage from *Harris v. McRae*, this Court noted that abortion is "inherently different from other medical procedures" precisely because it terminates a life. 448 U.S. at 325. And in *Ashcroft*, Missouri's requirement that a second physician be present to try to save the infant victim of a third-trimester abortion was upheld as a legitimate exercise of state regulation. 462 U.S. at 485. Just last Term, in the *Webster* case, the Chief Justice in abandoning *Roe*'s trimesters said:

> That framework sought to deal with areas of medical practice traditionally subject to state regulation, and it sought to balance once and for all by reference only to the calendar the claims of the State to protect the fetus as a form of human life against the claims of a woman to decide for herself whether or not to abort a fetus she was carrying.

109 S.Ct. at 3058. Since Illinois' statutes fall within the traditional regulation of medical practice, the claim of the right to abort, if any, must be balanced against the unique status of the unborn as a *patient*, not against the calendar. Viewed as a patient, the unborn child is entitled to consideration "of all attendant circumstances—psychological and emotional as well as physical—that might be relevant to the well-being of the patient." *Colautti v. Franklin*, 439 U.S. 379, 394 (1979). The ramifications are obvious and compelling. Prenatal patients cannot protect themselves; cannot be informed or give consent; cannot be made to understand their condition, nor can they choose treatments. Therefore, when faced with a surgical procedure having potentially fatal results, such patients must be afforded *at least* the regulatory protection afforded all other surgical procedures. Indeed, considered from this perspective, the state should be afforded more, not less, latitude to regulate or prevent the surgery known as abortion.

C. States Must Be Allowed to Protect Women From the Adverse Effects of Abortion.

Another reason that greater state regulation of abortion is called for is to minimize its known adverse effects. Two of the many tragic ironies of *Roe v. Wade* are: (1) it predicted great benefits would flow from constitutional abortion, yet failed to consider the many resulting detriments; and (2) it held that a woman's health was only of interest to the state after she had been pregnant for at least three months. 410 U.S. at 163. The inherent flaw in this latter point was, of course, illustrated by Justice O'Connor in *Akron*:

> The fallacy inherent in the *Roe* framework is apparent: just because the State has a compelling interest in ensuring maternal safety once an abortion may be more dangerous than childbirth, it simply does not follow that the State has no interest before that point that justifies state regulation to ensure that first-trimester abortions are performed as safely as possible.

462 U.S. at 460. The fallacy is remedied by protection of this interest throughout pregnancy. *Webster*, 109 S.Ct. at 3057. Indeed, as should have been obvious to the *Roe* majority, protection of women's health is of vital concern at all times; pregnancy should only heighten, not weaken, this concern. And, as has been demonstrated in the past sixteen years, abortion should raise the level of legitimate state concern even higher. This point is amply illustrated in Argument I.B., *supra*, where some of the serious physical and psychological consequences to women exploited by abortion are reviewed.

Despite these known consequences, persons supporting an "abortion privacy right" often characterize the anti-abortion stance as anti-woman. They frame the issue as

though it involved only a woman's right to "keep the government out of the bedroom." [47] Some further argue that women's childbearing capacities have been improperly used as a justification for discrimination against them, implying that a desire to oppress women supplies the *only* motivation for opposing abortion.[48] Finally, some claim that the only effective remedy for sexism is women's assumption of sole control over every aspect of their reproductive capabilities, including unfettered access to abortion.[49] These assertions are not only misleading, they are ultimately dangerous to women's health and well-being.

A consistent ethic is one that seeks women's true freedom. It recognizes that disrespect for the life of an unborn child erodes respect for women as well. Furthermore, as has been discussed in Argument I.A. above, the widespread, legitimized practice of abortion since *Roe*, with its attendant principle of personal autonomy, has increased pressure upon women to abort for a variety of discretionary and sometimes trivial reasons. By contrast, those who oppose unrestricted abortion willingly explore numerous alternative means for handling un-

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[47] Clift, King & Gonzalez, "Taking Issue With NOW," *Newsweek* 21-22 (Aug. 14, 1989). In the same article a Planned Parenthood consultant comments: "Framed that way, it becomes the all-American message."

[48] Gloria Steinem in "A Basic Human Right," *Ms.* 39 (Aug. 1989), states that "controlling women's bodies as the most basic means of production, the means of *re*production, [is] the very definition of patriarchy."

[49] *See, e.g.*, B. Harrison, *Our Right to Choose* 199 (1983): "Reproductive choice for women is requisite to any adequate notion of what constitutes a good society. Transformed social conditions of reproduction are absolutely critical to all women's well-being. . . . No society that coerces women at the level of reproduction may lay claim to moral adequacy."

wanted pregnancies.[50] Abortion's supporters neglect such alternatives in favor of vociferous abortion advocacy,[51] and in the midst of their arguments, what should be a paramount concern for the health and welfare of mother and child is lost.

The answer to the problems caused by abortion does not lie in making abortion more available but in efforts to ensure that no woman need ever resort to abortion. The process of change will not be easy; worthwhile solutions never are. This Court can help begin the turn from a society that accepts abortion while ignoring its insidious consequences, to one that protects the health of its citizens and respects the lives of their offspring. Restoring the traditional authority of Illinois and other states to regulate the medical profession in order to achieve these goals is an important first step.

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[50] These efforts include, *inter alia*, eliciting additional emotional and financial support from the father, family, and friends, additional social welfare support for families, better child care policies, and better adoption services. *See* National Conference of Catholic Bishops, *Pastoral Plan for Pro-Life Activities: A Reaffirmation* (Nov. 1985).

[51] Increasingly, feminist scholars and other women are expressing criticism of organizations which proclaim themselves spokespersons for women and yet direct the bulk of their efforts toward abortion rights rather than such abortion alternatives and standard-of-living initiatives. F. Ginsburg, *Contested Lives: The Abortion Debate in an American City* (1989); S. Hewlett, *A Lesser Life* 187-88, 190-91, 392 (1986). Szegedy-Maszak, "Planned Parenthood's Faye Wattleton, Calm, Cool and Beleagured," *The New York Times*, Aug. 6, 1989, at 62 (Magazine).

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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October Term, 1989.

BERNARD J. TURNOCK, M.D., M.P.H., et al.,
Appellants,

v.

RICHARD M. RAGSDALE, M.D., et al.,
Appellees.

ON APPEAL FROM THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF OF THE RUTHERFORD INSTITUTE AND THE RUTHERFORD INSTITUTES OF ALABAMA, ARKANSAS, CALIFORNIA, COLORADO, CONNECTICUT, FLORIDA, GEORGIA, KENTUCKY, MICHIGAN, MINNESOTA, MONTANA, NEBRASKA, OHIO, OKLAHOMA, PENNSYLVANIA, SOUTH CAROLINA, TENNESSEE, TEXAS, VIRGINIA, WEST VIRGINIA AND WISCONSIN, *AMICI CURIAE*, IN SUPPORT OF APPELLANTS

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TABLE OF CONTENTS

	PAGE
Table of Authorities	iii
Interest of Amici Curiae	1
Summary of Argument	2
Argument	4
I. *ROE* V. *WADE* SHOULD IN THE INTEREST OF JUSTICE BE EXPRESSLY OVERRULED	4
A. The Equivocacy of *Webster* and the Need to Reconsider *Roe* and *Doe*	4
B. Issues in This Case Requiring Reconsideration of *Roe* and *Doe*	12
II. *ROE* OVERVALUED THE WOMAN'S INTEREST IN AN ABORTION VIS-A-VIS THE COUNTERVAILING STATE INTERESTS	13
A. The *Roe* Standard	13
B. Toward A Post-*Roe* Standard	16
III. THE ILLINOIS STATUTES AND REGULATIONS DO NOT POSE ANY ABSOLUTE OBSTACLE OR SEVERE RESTRICTION ON ABORTION AND SHOULD THEREFORE BE UPHELD AS RATIONALLY RELATED TO THE STATE'S INTERESTS IN SAFE GUARDING MATERNAL HEALTH, PROTECTING THE UNBORN AND REGULATING MEDICAL PRACTICES	19
A. The Statutory and Regulatory Scheme	19

PAGE

B. The Standard of Review 20
1. Undue Burden Analysis 21
2. Rational Basis Test 24
IV. CONCLUSION 28

TABLE OF AUTHORITIES

Cases

Adkins v. *Children's Hospital*, 261 U. S. 525 (1923) . 29
Beal v. *Doe*, 432 U. S. 438 (1977) 17, 27
Belotti v. *Baird*, 428 U. S. 132 (1976) 17
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IN THE

Supreme Court Of The United States

October Term, 1989

BERNARD J. TURNOCK, M.D., M.P.H., et al.,
Appellants,

v.

RICHARD M. RAGSDALE, M.D., et al.,
Appellees.

ON APPEAL FROM THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF OF THE RUTHERFORD INSTITUTE AND THE RUTHERFORD INSTITUTES OF ALABAMA, ARKANSAS, CALIFORNIA, COLORADO, CONNECTICUT, FLORIDA, GEORGIA, KENTUCKY, MICHIGAN, MINNESOTA, MONTANA, NEBRASKA, OHIO, OKLAHOMA, PENNSYLVANIA, SOUTH CAROLINA, TENNESSEE, TEXAS, VIRGINIA, WEST VIRGINIA AND WISCONSIN, *AMICI CURIAE*, IN SUPPORT OF APPELLANTS

INTEREST OF AMICI CURIAE[1]

Amici Curiae — The Rutherford Institute and its affiliated state chapters — have as two of their purposes, fostering respect for the uniqueness and paramount worth of human life and its protection and preservation. These values are deeply rooted in America's common law and Constitutional tradition and its morality and values. Diminishing the value of human life, even "potential" human life, inexorably diminishes, in one form or another, the lives and the quality of life of all citizens. That is why

[1] Counsel of record to the parties in this case have consented to the filing of this brief and letters of consent have been filed with the Clerk pursuant to Rule 36.

The Rutherford Institute believes that this case, with issues concerning the power of states to regulate abortion, and ultimately, to sustain and protect human life, will be important to our Constitutional jurisprudence and to the growth and progress of the Nation.

Amici Curiae are non-profit religious corporations named for Samuel Rutherford, a 17th-century Scottish minister and Rector at St. Andrew's University. With state chapters in Alabama, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Kentucky, Michigan, Minnesota, Montana, Nebraska, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, South Carolina, Virginia, West Virginia and Wisconsin, and its national office in Charlottesville, Virginia, The Rutherford Institute undertakes to assist litigants and to participate in significant cases relating to the protection and safeguarding of human life. Counsel for *amici curiae* have specialized in litigation in state and federal courts and have participated as counsel for *amici curiae* in previous cases before this Court. The Rutherford Institute believes the expertise of its counsel will be of assistance to the Court in this case.

SUMMARY OF ARGUMENT

The need to reconsider the fundamental premises of *Roe* v. *Wade* and *Doe* v. *Bolton* is directly renewed by at least two specific issues presented in this case: (1) Illinois' requirement that all abortions be done in licensed ambulatory surgical treatment centers or hospitals, thereby subjecting first trimester abortions to state regulation, and (2) Illinois' abortion counseling requirements that arguably intrude into the sanctity of the doctor-patient relationship in abortion. Reconsideration of *Roe* and *Doe* cannot and should not, therefore, be further postponed on procedural niceties, but should be undertaken because there are imperative reasons to do so in this case.

First, the manifest legal error of *Roe* requires correction. *Roe*'s premises are not rooted in the tradition of the Nation. Its reading of history is flawed, its reliance on precedent, misplaced, and its Constitutionalization of an essentially legislative issue, mistaken. Second, *Roe*'s fundamental error, sown and reaped in

its progeny, has produced a "jurisprudence of minutae" that is plain and simply, "unworkable," a doctrinal garden that cannot be readily weeded or pruned through a progression of cases over time. Third, the national controversy spawned by *Roe* is in dire need of definitive resolution. After 15 years of national turmoil, and 20-odd, bitterly divided abortion cases, with no agreement in sight, it should be painfully evident to this Court that the ultimate resolution of this issue is uniquely suited, and best left, to the legislative process. In short, *Roe* has been imposed without Constitutional warrant upon a society that does not universally share the values it represents. A principled basis for reversal has been eloquently and convincingly stated by sitting Justices on this Court and it is respectfully submitted that the Court should now exercise its Thesean duty and spare the Nation yet further Procrustean agony inflicted by *Roe* v. *Wade*.

If this Court in *Webster* has instead chosen a course of gradualism — "modify[ing] and narrow[ing] *Roe* and succeeding cases" only to the extent necessary in the light of specific state action — then it appears that a woman's interest in an abortion as expressed in *Roe* has at least been overvalued in light of the state's countervailing interests. This would mean that states may now be permitted far more latitude in advancing significant state interests in regulating abortion at any point during a woman's pregnancy. And taking into account Justice O'Connor's views in *Akron* v. *Akron Center for Reproductive Health* and *Thornburgh* v. *American College of Obstetricians and Gynecologists*, it would appear that (1) strict judicial scrutiny of legislative action affecting abortion would now be limited to those cases which, in effect, impose an absolute ban or severe burden on a woman's ability to make the abortion decision and (2) judicial review of legislation restricting abortion would recognize a significant and appropriate role for the legislative branch in the promulgation of reasonable societal standards regulating such conduct.

When these "post-*Roe*" standards are applied to the Illinois licensing regime, it is clear that none of the Illinois requirements poses a "severe obstacle" or an "absolute veto" to the abortion decision. And Illinois' licensure standards for facilities performing surgical procedures, including abortions, must stand because they

are reasonably related to the state's legitimate objectives of encouraging normal childbirth and of protecting the health and safety of the mother and the unborn child throughout pregnancy.

ARGUMENT

I. *ROE* V. *WADE* SHOULD IN THE INTEREST OF JUSTICE BE EXPRESSLY OVERRULED.

A. The Equivocacy of *Webster* and the Need to Reconsider *Roe* and *Doe*.

The early reports that this Court's decision in *Webster* v. *Reproductive Health Services*, ___ U.S. ___, 109 S. Ct. 3040 (1989),[2] signaled the impending demise of *Roe* v. *Wade*[3] have, in the eyes of some, proved to be greatly exaggerated. At most, *Webster* put "abortion on demand" at risk. In the mean time, the wrenching of American society that began with *Roe* v. *Wade* not only continues unabated, but has been intensified by the inability of the *Webster* plurality to "command" a Court.

This lack of consensus among the *Webster* majority is surprising. The Court has been familiar enough with the issues. For the last fifteen years, it has engaged in a nearly annual ritual of parsing *ad nauseum* the abortion rules and regulations from various states. And the complaints from members of the Court about *Roe* and its alleged debilitating effect on the institution have grown increasingly more numerous and strident in recent years. *Webster*'s failure to produce a clear and definitive declaration thus not only further "distort[s] the public perception of the role of th[e] Court," it "preserve[s] a chaos that is evident to anyone who can read and count." *Webster*, 109 S. Ct. at 3065 (Scalia, J. concurring).

Perhaps most troubling about the *Webster* decision is the failure of a majority of the Nation's highest court to conclude that the Court should release its grip on abortion regulation. The fractured indecision[4] of the *Webster* majority serves little more

[2] Hereinafter referred to as *Webster*.

[3] *Roe* v. *Wade*, 410 U. S. 113 (1973) (hereinafter referred to herein as "*Roe*"). The companion case of *Doe* v. *Bolton*, 410 U. S. 179 (1973), is hereinafter referred to as "*Doe*".

[4] Justice Brandeis once said, "[t]he most important thing we do is not doing." A. Bickel, *The Least Dangerous Branch: The Supreme Court At The Bar of Politics*

than to perpetuate the oligarchic error of *Roe*. And the people and their elected representatives are left with patronizing consolation that there will be "time enough" for *Roe* v. *Wade* to be reconsidered. Leave the people to some indeterminate future time to know whether representative government will ever again be restored to what is otherwise a legislative issue in virtually all Western democracies.[5] And leave the Nation's lawmakers with a set of opinions that make it impossible to determine where the Court is headed or what laws — other than the narrow provisions of Missouri law upheld in *Webster* — will pass constitutional scrutiny. And leave to profiteering abortionists[6] rather than societal regulation the fate of hundreds of thousands more otherwise helpless human beings sacrificed every year by oftentimes victimized and uninformed women for little reason more than inconvenience.[7]

Postponing reconsideration of *Roe* is not only postponing the inevitable, it is tantamount to daring coordinate branches of government to act beyond their Constitutional authority. Instead of the states attempting to comply with the rule of law as expressed by this Court, for *Roe* to be reconsidered, it will apparently be necessary to flaunt *Roe* directly and proscribe abortion in some slightly more lenient manner than Texas or Georgia did in 1973. It is bad enough that legislation must pass litmus tests that comply with legal intricacies formulated by this Court in the admixture of

71 (1962). Unfortunately, indecision in the context of the errant judicial handiwork of *Roe* v. *Wade* is to affirm what was "decided" in *Roe*.

[5] Mary Ann Glendon, *Abortion and Divorce in Western Law* 24-25 (1987).

[6] In this case, Dr. Ragsdale's gross profit from the 3500 abortions performed at his clinic each year (1.7 per hour, based on a 5-day workweek) was $875,000.00 per year, and probably half again as much. *See Turnock* v. *Ragsdale*, 841 F.2d 1358, 1391-1392 (7th Cir. 1988) (Coffey, J., dissenting). This is typical for abortion practice which is "fast-track, quick-fix [and] volume-for-profit." Wardle, *Rethinking Roe v. Wade*, 1985 B.Y.U.L. Rev.at 244.

[7] According to a recent survey commissioned by the Alan Guttmacher Institute of 1900 women who obtained an abortion, the reasons for abortion were variously financial (21%); relationship problems (12%); not ready for responsibility (32%); already enough children (8%); would involve change in life style (16%); fetus has health problem (3%); mother has health problem (3%); rape or incest (1%); threat to life of the mother (none listed); other (3%). Torres and Forrest, *Why Do Women Have Abortions*, 20 Family Planning Perspectives 169 (1988).

state abortion regulation, but it is far worse to introduce an element of gamesmanship as between coordinate branches of government in order to induce this Court to decide whether *Roe* remains good law. And to condition reconsideration of *Roe* on whether some state Attorney General parrots a litany requesting that *Roe* be overruled, is to cast this Court's Constitutional discretion to the vagaries of the political process.

The failure to confront *Roe* v. *Wade* head-on in *Webster* need not, and should not, be repeated again in the abortion-related cases this Term of Court. The need to reconsider the fundamental premises of *Roe* v. *Wade* and *Doe* v. *Bolton* is directly renewed by specific issues presented in this case.[8] Reconsideration of *Roe* should, therefore, not be further postponed on procedural niceties, but should be undertaken directly because there are imperative reasons in this case to do so.

First and foremost, the manifest legal error of *Roe* requires correction. The pre-*Webster* abortion jurisprudence of this Court demonstrates "not just wrong turns on a generally propitious journey but indications of an erroneous point of departure."[9] *Roe*'s premises are not rooted in the tradition of the Nation. Its reading of history is flawed,[10] its reliance on precedent, misplaced,[11] and

[8] For a discussion of the two specific issues in this case that bring the validity of *Roe* and *Doe* directly into question, see Part B of this Heading.

[9] *Brief for the United States As Amicus Curiae in Support of Appellants* in *Thornburgh* and *Diamond* v. *Charles*.

[10] *See*, Byrn, *An American Tragedy: The Supreme Court on Abortion*, 41 Ford. L. Rev. 807, 814-835 (1973); Destro, *Abortion and the Constitution: The Need for a Life-Protective Amendment*, 63 Calif. L. Rev. 1250, 1267-1282 (1975); Dellapena, *The History of Abortion: Technology, Morality and Law*, 40 U. Pitt. L. Rev. 359, 365-416 (1979); *Special Project: Survey of Abortion Law*, 1980 Ariz. St. L. J. 67, 75-76, 79-88; Connery, *The Ancients and the Medievals on Abortion: The Consensus the Court Ignored*, in *Abortion and the Constitution*, 123-135 (D. Horan, E. Grant & P. Cunningham, ed. 1987); Arbagi, *Roe and the Hippocratic Oath*, in *id*. at 159-181; Horan & Balch, *Roe v. Wade: No Justification in History, Law, or Logic*, in *id*. at 57.

[11] This Court's cases involving marriage, contraception, procreation, education and family relationships, upon which *Roe* relied, involved non-destructive, normative conduct that has been historically and traditionally recognized as contributing to the social and moral order. The individual freedom recognized in those cases

its Constitutionalization of an essentially legislative issue, mistaken. Weighed against history, precedent, and the separation of governmental powers, the decision in *Roe* to extend the zone of personal privacy to include termination of pregnancy represents a transposition of values. In the name of "liberty", an essentially destructive, anti-social value has been elevated over the value of "life" itself. This, despite a strong common law tradition permitting the state to preserve and protect potential human life and proscribe abortion, and an equally, if not more, important Constitutional tradition that accords as great a value to "life" as to "liberty." One need only consider the text of our Founding documents—the Declaration of Independence and the Fifth Amendment to the Constitution, as well as the Fourteenth Amendment and Article 1, Sections 1 and 2 of the Illinois Constitution of 1970 to understand the importance ascribed to "life" in our history and tradition. It cannot be gainsaid that the right to life is the "compelling basis of the dignity of man and... the *pre-condition* for *all* basic constitutional rights."[12] It is ironic that the state's interest in its system of taxation would be deemed by this Court to be so compelling as to override even expressly granted

in connection with marriage, child rearing and family life promote interdependence and commitment in primary relationships that are the foundation of community in society. And procreative freedom, certainly in the context of *Griswold* v. *Connecticut*, 381 U. S. 479 (1965), is a prerequisite to the social order and "fundamental to the very existence and survival of the race." *Skinner* v. *Oklahoma*, 316 U. S. 535, 541 (1942). It is therefore different in kind from abortion.

Abortion, on the other hand, is, and always has been, a destructive and aggressive action, *i.e.* the killing of "unwanted" natural life. As Blackstone said, "[t]o *kill* a *child* in it's mother's womb, is now no murder, but a great misprison...." W. Blackstone, 4 *Commentaries on the Laws of England* 198. Abortion represents isolation — a pushing away that is frequently the product of relationships lacking permanent commitment. More in the nature of assault, abortion is conduct which has traditionally been subject to state regulation and control and certainly cannot be characterized as fundamental, whether by tradition or otherwise, in the sense of the freedoms recognized above.

[12] Decision of The Federal Constitutional Court of the Federal Republic of Germany (West Germany), translated in Jonas & Gorby, *West German Abortion Decision: A Contrast to Roe v. Wade — With Commentaries*, 9 J. Mar. J. Prac. & Proc. 551, 642 (1976).

First Amendment guarantees,[13] whereas the state's interest in protecting human life is allowed to be emasculated by penumbras of privacy discerned by this Court in the Due Process Clause — as prevaricated a jurisprudence as there ever could be, and all incredibly based on alleged "Constitutional" values.

The problem with continuing to accord *Roe* even limited deference as controlling precedent is that it artificially constricts constitutional analysis and inexorably colors the outcome of every abortion case. *Roe*'s fundamental error, sown and reaped in its progeny, has created a "jurisprudence of minutae"[14] that is plain and simply, "unworkable,"[15] a doctrinal garden that cannot be readily weeded or pruned through a progression of cases over time. *Roe* has multiplied into "a web of legal rules that have become increasingly intricate, resembling a code of regulations rather than a body of constitutional doctrine."[16] Those "rule[s] can only be as sound as the doctrine [they] attempt to service".[17] When the underlying doctrine fails "to trace its premises to the charter from which it derives its authority"[18] and deprives the people of power to explore and shape a societal response to a controversial subject involving important, but conflicting social values,[19] both the doctrine and the rules must be rejected and discarded. Like the old substantive economic due process doctrine, *Roe* and *Doe*

[13] *See, e.g., United States* v. *Lee*, 455 U. S. 252(1982); *Texas Monthly, Inc.* v. *Bullock*, ___ *U. S.* ___ 109 S.Ct. 890 (1989); *Bowen* v. *Roy*, 476 U. S. 693 (1986).

[14] *County of Allegheny* v. *American Civil Liberties Union*, ___ U. S. ___, 109 S.Ct. 3086, 3144 (1989) (Kennedy, J., dissenting).

[15] *Garcia* v. *San Antonio Metropolitan Transit Authority*, 469 U. S. 528, 546 (1985).

[16] *Webster*, 109 S.Ct. at 3057.

[17] *Wallace* v. *Jaffree*, 472 U. S. 38, 110 (1985)(Rehnquist, J., dissenting).

[18] Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 Yale L. J. 920, 949 (1973).

[19] Freund, *Storms Over the Supreme Court*, 69 A.B.A.J. 1474, 1480 (1983). *See also, Thornburgh* v. *American College of Obstetricians and Gynocologists*, 476 U. S. 747, 786-794, 796-797 (1986) (White, J. dissenting) (hereinafter referred to herein as "*Thornburgh*"), and *Bowers* v. *Hardwick*, ___ *U. S.* ___, 106 S. Ct. at 2844-46 (1986).

should be recognized for what they are, "derelict[s] in the stream of the law."[20]

The controversy spawned by *Roe* is in dire need of definitive resolution. After 15 years of national turmoil, and 20-odd, bitterly divided abortion cases, with no agreement in sight, it should be painfully evident to this Court that the ultimate resolution of this issue is uniquely suited, and best left, to the legislative process. The pre-*Webster* majority of the Court already attempted a definitive resolution in the *Akron*[21] and *Thornburgh* cases, where it sought to affirm *Roe* in the strongest terms. But the resort to the formalism of *stare decisis* in *Akron* and *Thornburgh* proved that even the most formidable legal talisman cannot justify a decision as wanting in precedent and cultural roots as *Roe* v. *Wade*. And the Court's incantation of *Brown* v. *Board of Education*[22] in *Thornburgh*, apparently an attempt to analogize *Roe* with another controversial precedent, was inappropriate because *Brown* was secure in its Constitutional warrant *and* its moral content: "the fourteenth amendment provided an explicit and settled constitutional mandate to justify that decision, apart from the moral force of the decision's reasoning.[23] To the contrary, *Roe*'s illegitimacy is now well nigh legendary.[24] Three Justices questioned its

[20] *North Dakota State Board of Pharmacy* v. *Snyder's Drug Stores, Inc.*, 414 U. S. 156, 167 (1973).

[21] *Akron* v. *Akron Center for Reproductive Health*, 462 U. S. 416 (1983) (hereinafter referred to as "*Akron*").

[22] 349 U.S. 294 (1955).

[23] Knicely, *The Thornburgh and Bowers Cases: Consequences for Roe v. Wade*, 56 Miss. L. J. 267, 282 (1986).

[24] This Court "is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution." *Bowers* v. *Hardwick*, 106 S.Ct. 2841, 2846 (1986). Legitimacy is essential because the judiciary "is uniquely dependent upon the power of legitimacy when engaged in constitutional adjudication." A. Cox, *The Role of the Supreme Court in American Government* 103 (1976). Absent legitimacy, respect for law is greatly diminished, legal institutions are undermined, law enforcement is jeopardized, and the gap between the law and the moral order produces increasing conflict and social turmoil. The judiciary is otherwise left to the embarrassing and defensive position of justifying its misadventures under increasingly indiscriminate standards. *See Thornburgh*, 476 U. S. at 814 and 829 (O'Connor, J., dissenting).

legitimacy in the *Thornburgh* case, with a fourth calling for its re-examination.[25] And the problems endemic with *Roe* make it the target of routine and persistent criticism, whether by the Executive Branch of the United States Government,[26] by distinguished legal scholars,[27] by the legislative branches of the Federal and several state governments,[28] by the people in referenda in several states[29] and by significant segments of American society,[30] not to mention the "Con-law" professors and students in hundreds of law schools in the Nation who annually put *Roe* through its paces and find it wanting in prudence, as well as constitutional content.[31]

[25] Justices White and O'Connor, both joined by then Justice Rehnquist, disputed the legitimacy of *Roe*. *Thornburgh* 476 U. S. at 791 (White, J., dissenting) and 829 (O'Connor, J., dissenting). Chief Justice Burger called for re-examination of *Roe*. *Id*. at 785 (Burger, C. J., dissenting).

[26] The last seven years has seen repeated solicitations by the Executive Branch of the United States Government, through its successive Solicitor Generals, imploring this Court to confine *Roe* v. *Wade* to its narrow holding or to overrule it. *See Briefs for the United States As Amicus Curiae in Support of Appellants* in *Akron*, *Thornburgh* and *Webster*.

[27] "As time passes, not only does the *Roe* decision appear to be collapsing from within, but the opinions of leading constitutional law writers, many of them not opposed to abortion in principle, have been marshaled against it. Archibald Cox, Alexander Bickel, John Hart Ely, Harry Wellington, Richard Epstein and Paul Freund have all been highly critical." Mary Ann Glendon, *Abortion and Divorce in Western Law* 44 (1987).

[28] *See, e.g., The Human Life Bill: Hearings on S. 158 Before the Subcommittee on Separation of Powers of the Senate Comm. on the Judiciary*, 97th Cong., 1st Sess. (1982); *see also*, the widespread legislation withdrawing Federal and state funding of abortion or otherwise regulating or restricting abortion, all enacted since 1973.

[29] *3 State Referendums Give New Impetus to Anti-Abortion Efforts*, The Washington Post, November 10, 1988, at B-1.

[30] *250 Arrested at Jersey Anti-Abortion Protest*, The New York Times, September 18, 1988, at 46; Thompson, *Atlanta Police Use Tougher Tactics As Abortion Foes Return to Streets*, The Washington Post, October 5, 1988, at A3; Abramowitz, *153 Arrested in Abortion Protest at D. C. Clinic*, The Washington Post, January 24, 1989, at B1.

[31] In the words of Archibald Cox, "[n]either historian, layman, nor lawyer will be persuaded that all the details prescribed in *Roe* v. *Wade* are part of either natural law or the Constitution." A. Cox, *The Role of the Supreme Court in American Government* 114 (1976). *See generally*, Ely, *supra* note 18.

In short, *Roe* has been imposed without Constitutional warrant upon a society that does not universally share the values it represents. "There can be no doubt of the strength of the conviction held by some that free access to abortion is a fundamental expression of individual freedom, and that such freedom is the first principle of a just society.... Yet this conviction does not constitute constitutional argument. It is at best an intuition based in controversial moral and social theories of the good life and an individual's situation in society, theories 'which a large part of the country does not entertain.' *Lochner* v. *New York*, 198 U. S. at 75 (Holmes, J., dissenting)."[32] *Roe* is obviously not grounded in the values and traditions of the Nation and it will remain so until it is reversed.[33] A principled basis for reversal has been eloquently and convincingly stated[34] by sitting Justices on this Court and it is respectfully submitted that the Court should now exercise its Thesean duty and spare the Nation yet further Procrustean agony inflicted by *Roe* v. *Wade*.[35]

[32] *Brief of the United States as Amicus Curiae In Support of the Appellants in Thornburgh* at 29.

[33] In the Lincoln-Douglas debates, the Court's equally controversial *Dred Scott* decision declaring blacks to be chattels and not citizens brought about the following discourse:

> "I yield obedience," Douglas said, "to the decisions of that Court — to the final determination of the highest judicial tribunal known to our Constitution." To this Lincoln countered by deriding the notion that a decision of the Supreme Court is a "Thus saith the Lord." "The Court," he said, "can be wrong. There is nothing sacred about the Court's decisions."

A. Bickel, *The Least Dangerous Branch: The Supreme Court At the Bar of Politics* 259 (2d ed. 1986).

[34] *Thornburgh*, 476 U. S. at 786-797 (White, J., dissenting); *Akron*, 462 U. S. at 453-459 (O'Connor, J., dissenting).

[35] This Court has abandoned error well over 100 times in its history. *See*, Blaustein and Field, *'Overruling' Opinions in the Supreme Court*, 57 Mich. L. Rev. 152-156 (1958); Pfeifer, *Abandoning Error: Self-Correction by the Supreme Court*, in *Abortion and the Constitution*, *supra* note 10, at 3-22.

B. Issues in This Case Requiring Reconsideration of *Roe* and *Doe*.

Although the Illinois licensing scheme contains many different provisions, the constitutional validity of at least two of the Illinois statutes and regulations turns *directly* on the constitutional validity of *Roe* v. *Wade* and *Doe* v. *Bolton*.

First, Section 16(1) of the Medical Practice Act (111 Ill. Rev. Stat. Para. 4433(1)), coupled with Paragraph 157-8.3(A) of the Ambulatory Surgical Treatment Center Act (111-1/2 Ill. Rev. Stat. Para. 157-8.1 *et seq.*)(*"ASTCA"*) *require* that abortions be performed only in facilities licensed as ambulatory surgical treatment centers ("ASTCs") or in hospitals. This directly contravenes the trimester framework of *Roe* where, the Court said, during the first trimester, "the attending physician, in consultation with his patient, is free to determine, *without regulation by the state*, that, in his medical judgment, the patient's pregnancy should be terminated." *Roe*, 410 U. S. at 163. It also directly contravenes the requirements of *Doe* v. *Bolton*, where this Court invalidated a licensing requirement limiting abortions to certain accredited hospitals, stating: "This is not to say that Georgia may not or should not, *from and after the end of the first trimester*, adopt standards for licensing all facilities where abortions may be performed so long as those standards are legitimately related to the objective the State seeks to accomplish." *Doe*, 410 U. S. at 194-195.

In addition to the first trimester problem, two provisions of the *Illinois Minimum Standards, Rules and Regulations For the Licensure of Ambulatory Surgical Treatment Centers*[36] ("Licensing Regulations") run afoul of *Roe*'s requirement that "the abortion decision in all its aspects is inherently, and primarily, a medical decision....up to the points where important state interests provide compelling justifications for intervention...." *Roe*, 410 U. S. at 166-167. This requirement has been further elaborated upon in the *Danforth*,[37] *Akron* and *Thornburgh* cases. In the latter case, the Court said:

[36] Title 77, Chapter 1, Part 205, Illinois Administrative Code: Public Health.

[37] *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U. S. 52 (1976).

> [A] rigid requirement that a specific body of information be given in all cases, irrespective of the particular needs of the patient, intrudes upon the discretion of the pregnant woman's physician and thereby imposes the 'undesired and uncomfortable straitjacket' with which the Court in *Danforth* was concerned....Forcing the physician or counselor to present the materials and the list to the woman makes him or her in effect the agent of the State in treating the woman and places his or her imprimatur upon both the materials and the list.

Thornburgh, 476 U. S. at 762. Per contra, Section 205.730(b)(3) of the Licensing Regulations requires that counseling be done at an ASTC prior to an abortion and further that counseling *shall* include a "discussion of alternatives, description of the procedure to be performed, explanation of risks and possible complications." Moreover, Section 205.730(b)(2)(D) provides that "counselors shall have no financial interest in the patient's decision." These requirements unquestionably intrude upon "the basic responsibility" of the physician and, in fact, arguably structure the counseling the physician or others may give. They also arguably proscribe, and certainly limit, physician participation in counseling because of his or her financial stake in performing the abortion.

It would be evading reality to ignore these direct conflicts with the basic regime of *Roe* and *Doe*. This Court must, therefore, inevitably address the validity of those decisions in this case.

II. *ROE* OVERVALUED THE WOMAN'S INTEREST IN AN ABORTION VIS-A-VIS THE IMPORTANT STATE INTERESTS INVOLVED.

A. The *Roe* Standard.

Abortion is a surgical procedure. As with any medical or surgical procedure, there is unquestionably a Fourth, Fifth and Fourteenth Amendment "liberty" interest for a person to be free from state interference in seeking, obtaining or refusing appropriate medical treatment,[38] whether that interest is denominated as a privacy interest or otherwise. What distin-

[38] *See, e.g., Winston* v. *Lee*, 470 U. S. 753, 758-763 (1985); *Rochin* v. *California*, 342 U. S. 165, 172-174 (1951).

guishes abortion from other medical procedures is that there are two human beings — the mother and the unborn child — who are directly at risk in the abortion decision (not to mention other significant interests like those of the father).

Roe acknowledged that "[t]he pregnant woman cannot be isolated in her privacy." 410 U. S. at 159. And this Court has also indicated that "[a]bortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of potential life." *Harris* v. *McRae*, 448 U. S. 297, 325 (1980). The presence of the unborn child, therefore, removes the abortion decision as a strictly personal decision affecting only the woman. Because another individually distinct human life is at risk, there is an understandable societal interest in the decision to terminate that life. However one characterizes the woman's interest, that interest is diminished by the fact that the abortion decision involves the killing of human life.

This Court has said that the extent of the interests involved in an abortion "can be understood only by considering *both* the woman's interest and the nature of the State's interference with it." *Maher* v. *Roe*, 432 U. S. 464, 473 (1977) (emphasis added). *Roe*, of course, deemed the woman's interest to involve a privacy right recognized as fundamental under the Due Process Clause. On the other hand are the state's legitimate interests advanced to regulate abortion, some of which this Court has previously recognized as compelling. These interests include: (1) protecting "potential human life,"[39] i.e. the life of the unborn child, which necessarily includes protecting its health as well;[40] (2) safeguarding maternal health[41] (3) maintaining medical standards;[42] (4)

[39] *Roe*, 410 U. S. at 162.

[40] The state has a compelling governmental interest in "protecting those who will be citizens if their lives are not ended in the womb. The substantiality of this interest is in no way dependent upon the probability that the fetus may be capable of surviving outside the womb at any given point of its development...." *Thornburgh*, 476 U. S. at 795 (White, J. dissenting).

[41] *Roe*, 410 U.S. at 162.

[42] *Roe*, 410 U. S. at 155; *Williamson* v. *Lee Optical Co.*, 348 U. S. 483 (1955).

protecting parental rights[43] and promoting family integrity[44] and (5) encouraging normal childbirth over abortion.[45] This is not to say that there are not other interests that states may advance or choose to advance in the future, such as psychological harm to the woman[46] and causing inhumane pain and suffering to the unborn child.[47]

Prior to *Roe*, most states asserted an interest in protecting and preserving the life of the unborn child by proscribing abortion

[43] *Meyer* v. *Nebraska*, 262 U. S. 390 (1923); *Pierce* v. *Society of Sisters*, 268 U. S. 510, 535 (1926); *Prince* v. *Massachusetts*, 321 U. S. 158, 166 (1944); *Wisconsin* v. *Yoder*, 406 U. S. 205, 232 (1972); *Stanley* v. *Illinois*, 405 U. S. 645, 651 (1972); *Parham* v. *J.R.*, 442 U. S. 584 (1979).

[44] *H.L.* v. *Matheson*, 450 U. S. 398, 411 (1981) (familial integrity); *see also* Peirce, *BRI v. Leonard: The Role of the Courts in Preserving Family Integrity*, 23 N. Eng. L. Rev. 185 (1988); Mattinson, *The Effects of Abortion on a Marriage* in *Abortion: Medical Progress and Social Implications*, 1985 Ciba Foundation Symposium 165-177; McAll & Wilson, *Ritual Mourning for Unresolved Grief*, 80 Southern Medical Journal 817 (1987); Furlong & Black, *Pregnancy Termination for Genetic Indications: The Impact on Families*, 10 Social Work in Health Care 1 (1984).

[45] *Maher* v. *Doe*, 432, U. S. 464, 478 (1977).

[46] There has been much speculation, but apparently no definitive research, about the "post abortion syndrome" or other psychological problems associated with abortion. In a February 5, 1989, article in The Washington Post, Colman McCarthy writes that scientific studies abroad indicate that "[t]he incidence of serious, permanent psychiatric aftermath [from abortion] is variously reported as between 9 and 59 percent." He also quotes one Washington, D. C., abortionist, Dr. Julius Fogel, a psychiatrist who has performed and observed the effects of 20,000 abortions, as saying:

> There is no question about the emotional grief and mourning following an abortion....[A] psychological price is paid. I can't say exactly what. It may be alienation, it may be a pushing away from human warmth, perhaps a hardening of the maternal instinct. Something happens on the deeper levels of a woman's consciousness when she destroys a pregnancy. I know that as a psychiatrist.

McCarthy, *The Real Anguish of Abortions*, The Washington Post, February 5, 1989, at F2.

[47] *Thornburgh*, 476 U. S. at 778 (Stevens, J., concurring); *Webster*, 109 S.Ct. at 3085 (Stevens, J. concurring).

in *all* instances except where the life of the mother was threatened. *Roe* changed that overnight by severely limiting the state interest in potential human life and ostensibly segmenting whatever state regulatory power remained into trimesters. The state's interests in "maternal health" and "potential life" became, in effect, *in choate*, and were deemed compelling only as the pregnancy progressed to term and the unborn child reached viability. In practice, however, this scheme readily allowed for termination of unborn life at any time[48] for virtually any reason.[49]

Roe also propagated a new substantive due process right for physicians — the so-called "sanctity" of the doctor-patient relationship in abortion — and accorded extraordinary protection against any state action affecting that relationship, at least in an abortion context. State regulatory statutes that purportedly departed from "accepted medical practice" were regularly invalidated. The combined effect of these factors made it very difficult, if not impossible, for states to exercise any regulation whatsoever of abortion or abortion procedures unless its laws tracked provisions previously approved by this Court. The result was to transform this Court, in effect, into a "Council of Revision" on the 50 states' laws governing abortion, unfortunately encumbering it with the substantial burdens inherent in such assumed legislative responsibility.[50]

B. Toward A Post-*Roe* Standard.

Fifteen years of "experience and... facts newly ascertained"[51] have demonstrated that the *Roe* framework is both "unwork-

[48] Koop, *The Slide to Auschwitz*, in R. Reagan, *Abortion and the Conscience of the Nation*, 41, 45 (1984); J. T. Noonan, *A Private Choice* 12(1979); Will, *Splitting Differences*, Newsweek, February 13, 1989 at 86; *Thornburgh*, 476 U. S. at 783-784 (Burger, C. J., dissenting).

[49] *See* note 7, *supra*.

[50] Abortion regulation "is an unfair burden to impose upon any Constitution. It is especially unfair to impose it on a Constitution that contains no mention of the words 'privacy' or 'abortion' and that can be extended to those matters only by piecing together a combination of shadows from a variety of explicit guarantees contained in the document." *Brief of the United States As Amicus Curiae in Support of the Appellants in Akron* at 19.

[51] *Burnet* v. *Coronado Oil & Gas Co.*, 285 U. S. 393, 412 (1932) (Brandeis, J., dissenting).

able"[52] and "problematic."[53] It is, therefore, necessary to revisit the public and private interests involved. Three Justices have expressed the view that the woman's interest in an abortion is a "liberty interest protected by the Due Process Clause."[54] *Webster*, 109 S.Ct. at 3058. Justice Scalia would apparently overrule *Roe* and leave the states free to legislate concerning abortion, subject only to the general requirement that legislation bear a rational relationship to a legitimate state objective. *Id.* at 3064. Justice O'Connor has indicated in her previous opinions that whatever interest a woman has in an abortion, the state may legislate so long as legislation is rationally related to a legitimate governmental goal and places no absolute obstacle in the path of a woman who chooses to terminate her pregnancy.[55] Only in cases where particular state action poses an "absolute veto" or a "severe burden" on the abortion right would Justice O'Connor apparently employ strict scrutiny of the state restriction and then determine whether the state's interest "unduly burdens" the woman's interest in abortion. *Harris* v. *McRae*, 448 U. S. 297, 314 (1980). Conceivably, the burden imposed by the state interest may in some circumstances be so compelling as even to override the liberty interest comprising the abortion right.[56]

Reconciling what might appear to be disparate views on the Court is an admittedly perennial problem in Constitutional litiga-

[52] *Garcia* v. *San Antonio Metropolitan Transit Authority*, 469 U. S. 528, 546 (1985).

[53] *See Webster*, 109 S.Ct. at 3056 (plurality opinion); and at 3063 (O'Connor, J., dissenting); *Thornburgh*, 476 U. S. at 828-830 (O'Connor, J., dissenting); and *Akron*, 462 U. S. at 453-459 (O'Connor, J., dissenting).

[54] Chief Justice Rehnquist, Justice White and Justice Kennedy joined in Part D of the plurality opinion in *Webster*.

[55] *See, Akron*, 462 U. S. at 461-466 (O'Connor, J., dissenting) and *Thornburgh*, 476 U. S. at 828-830 (O'Connor, J. dissenting); *see also*, *Webster*, 109 S.Ct. at 3051, 3056-3058; *Harris* v. *McRae*, 448 U. S. 297, 315, 325 (1980); *Maher* v. *Roe*, 432 U. S. 464, 473 (1977); *Beal* v. *Doe*, 432 U. S. 438, 446 (1977); and *Belotti* v. *Baird*, 428 U. S. 132, 147 (1976).

[56] *See Akron*, 462 U. S. at 473-474 (O'Connor, J., dissenting); *Thornburgh*, 476 U.S. at 828 (O'Conner, J., dissenting). *Cf. United States* v. *O'Brien* 391 U. S. 367 (1968); *Chaplinsky* v. *New Hampshire*, 315 U. S. 568 (1942); *Feiner* v. *New York*, 340 U. S. 315 (1951).

tion. In the *Webster* case, the Court has either deliberately or perhaps involuntarily chosen a course of gradualism — "modify[ing] and narrow[ing] *Roe* and succeeding cases"[57] only to the extent necessary in the light of specific state action. If this is truly the course the Court has embarked upon, then *Webster*, coupled with the prior writings of Justice O'Connor in *Akron* and *Thornburgh* appears, at a minimum, to stand for the proposition that a woman's interest in an abortion as expressed in *Roe* has been overvalued in light of the state's conflicting interests. It would also appear from this collection of views that states will now be permitted far more latitude in advancing their significant state interests in regulating abortion, including without limitation, at any point during a woman's pregnancy. And it would also appear that the Court may be receptive to a more traditional legal analysis that avoids "the Procrustean bed" fashioned by *Roe*[58] and instead, (1) limits strict judicial scrutiny of legislative action affecting abortion to those cases which, in effect, impose an absolute ban on a woman's ability to make the abortion decision and, (2) at the same time, recognizes a significant and appropriate role for the legislative branch in the promulgation of reasonable societal standards to regulate abortion.

This shift of analytical method is not only grounded in precedent and sound as a matter of logic, it also reinforces important values. As Professor Glendon urges in her study of the abortion laws of 20 Western countries,

> [p]erhaps it is fitting that abortion law at present should mirror our wonder as well as our ignorance about the mystery of life, our compassion for women who may be frightened and lonely in the face of a major crisis, and our instinctive uneasiness at terminating a form of innocent human life, whether we call it a fetus, an embryo, a baby or an unborn child.

Mary Ann Glendon, *Abortion and Divorce in Western Law* 46, (1987). Removing a significant amount of abortion regulation

[57] *Webster*, 109 S.Ct. at 3058. In *Thornburgh*, Justice White, joined by Chief Justice Rehnquist, wrote a more comprehensive dissent suggesting a broad range of grounds on which *Roe* should be directly overruled.

[58] *Webster*, 109 S.Ct. at 3056.

from strict constitutional scrutiny comports far more with American history and tradition and acknowledges far better than the present jurisprudence the proper role that the courts, the legislatures, the people and the affected parties all have to contribute in resolving this issue.

III. THE ILLINOIS STATUTES AND REGULATIONS DO NOT POSE ANY ABSOLUTE OBSTACLE OR SEVERE RESTRICTION ON ABORTION AND SHOULD THEREFORE BE UPHELD AS RATIONALLY RELATED TO THE STATE'S INTERESTS IN SAFEGUARDING MATERNAL HEALTH, PROTECTING THE UNBORN AND REGULATING MEDICAL PRACTICES.

Illinois has chosen to require that abortions be done in licensed surgical clinics or hospitals which meet certain standards. It has chosen to do so in the interests of the health of its citizens. By virtue of the abortion specific portions of its statutes and regulations, it has obviously done so to safeguard maternal health, to protect and preserve the health and life of the unborn child and to encourage normal childbirth. The question, then, is whether the Illinois licensing regime infringes upon a woman's Due Process interest in an abortion and, if so, whether the state's legitimate interests, be they compelling or otherwise, justify that infringement.

A. The Statutory and Regulatory Scheme

The Court of Appeals majority appears to have commenced its review of the Illinois statutes and regulations using the *Thornburgh* "canon" of construction, namely, that "'in cases involving abortion, a permissible reading of the statute is to be avoided at all costs.'"[59] Judge Coffey's devastating dissent demonstrates conclusively that the majority was operating upon unfounded surmise and suspicion when it (1) characterized the ASTCA as "enacted primarily with abortion clinics in mind" and (2) accused the Illinois legislators of subterfuge in making the ASTCA applicable to "outpatient surgical clinics generally only to

[59] *Thornburgh*, 476 U. S. at 829 (1986) (O'Connor, J., dissenting, *quoting* White, J., dissenting in the same case).

save the statute from unconstitutionality" and in using "the expedient and conclusory label 'surgery'" to apply to abortion which the majority hypothesized was simply a "medical procedure." 841 F.2d at 1369.

Without repeating the irrefutable legislative history fully related in Judge Coffey's dissent,[60] the facts of that history unequivocally demonstrate that the ASTCA was enacted in 1973 *not* primarily with abortion in mind, but as part of a national legislative trend toward state regulation of free-standing ambulatory surgical centers like those that first opened in Phoenix, Arizona, in 1970. Moreover, the ASTCA was designed not only to advance public health and safety for non-hospital surgical procedures, but also to promote and encourage cost-effective procedures. And the plaintiffs' own medical experts indicated that abortion was a *surgical* procedure and *Roe* suggests that it is too. *Turnock* v. *Ragsdale*, 841 F.2d 1358, 1387 (7th Cir.) (Coffey, J., dissenting). Suffice it to say that the *Ragsdale* majority's relatively loose treatment of the legislature's intent and the evidence reflects, at best, the same "undesirable judicial activism"[61] and defensiveness of the judicial prerogative that has caused this Court to ignore longstanding procedural rules and other standards in furtherance of its effort to impose abortion on demand on the 50 States.[62]

B. The Standard of Review.

The Court of Appeals majority applied an improper standard of review for the Illinois statutes and regulations. That standard required that "where first trimester abortions are involved, not only must the impact of the challenged regulation be insignificant in terms of the woman's exercise of her right, but also the regulation must be 'justified by important state health objectives.'" *Turnock* v. *Ragsdale*, 841 F.2d 1358, 1368 (7th Cir. 1988). This pre-*Webster* test imposes a presumptive balance of interests that is heavily weighted against the state. It is, in sum, as the Court of Appeals majority admitted, a "medical necessity" standard that subjects all state regulation of abortion to strict scrutiny. *Id.*

[60] 841 F.2d at 1376-1382.

[61] 841 F.2d at 1382.

[62] *Thornburgh*, 476 U. S. at 814, 829 (O'Connor, J., dissenting).

In the context of the present case, and in light of *Webster*, the inquiry must, instead, focus on the nature of the restriction imposed by the statutes and/or regulations promulgated by the State of Illinois. If they pose an "absolute obstacle" or "severe limitation" on a woman's liberty interest with respect to abortion, whether as an "absolute veto" of a woman's abortion decision, or otherwise as to "frustrate" or "heavily burden" the exercise of any constitutional interest, then the state regulation must be strictly scrutinized in light of the state interests advanced. Absent such overly intrusive or proscriptive measures, the State of Illinois' statutory and regulatory requirements need only demonstrate a rational relationship to a legitimate state objective.

1. Undue Burden Analysis.

The *Ragsdale* case, of course, was decided without the benefit of this Court's opinions in the *Webster* case. Under the then controlling *Roe* regime, the several statutes and regulations were preliminarily enjoined as unconstitutional.[63] The entire panel of the Seventh Circuit held that two of the Illinois requirements contravened *Roe*, namely, (1) that all abortions be performed in licensed ASTCs or hospitals and (2) that abortion counseling in ASTCs be done by persons not having any financial interest in the woman's decision. The former requirement ran directly contrary to *Roe*'s trimester framework and the ACOG standards cited in *Akron* relating to the safe performance of abortions in physicians' offices. The latter requirement was deemed to interfere unduly with the doctor-patient relationship protected by *Roe*. 841.F.2d 1398. As for the remainder of the licensing scheme, a majority of the panel held it to be unconstitutional. Judge Coffey, in dissent,

[63] This case arose on plaintiffs' motion for a preliminary injunction and was decided on a limited record developed pursuant to that motion. In addition to considerations of irreparable injury to the movant and harm to the public that might arise from denying or granting the motion, the district court was required in this case to consider plaintiffs' likelihood of success on the merits. *See Thornburgh*, 476 U. S. at 817-818 (O'Connor, J., dissenting). The review of this case on appeal should, therefore, be based on plaintiffs' "likelihood of success" in challenging the Constitutional validity of the Illinois statutes and regulations.

would have upheld the remaining licensure provisions as rationally related to the state's power to protect the public health.[64]

With the intervening decision in *Webster*, the various Illinois requirements must now be reviewed afresh in the light of that decision. Do the requirements that abortions be performed in licensed ASTCs or hospitals or that counseling be done by persons not having a financial interest in abortion impose a "severe burden" on or "obstacle" to the abortion decision? And do the other licensing requirements likewise impermissibly interfere with the abortion decision.

Certainly nothing in the licensing requirements presents any sort of "absolute veto" over a woman's choice to have an abortion. Neither the state nor any other party is accorded the power to override a woman's decision to abort. The certificate of need requirement providing for a public hearing for ASTC licensure does not make the woman's decision to obtain an abortion subject to "a public veto." As Judge Coffey noted, "[i]t stretches the imagination that one would write that the exercise of one's First Amendment rights to object to an issue be treated somehow as creating a burden on a woman's right to an abortion." 841 F.2d at 1393. The fact that there are many *licensed* ASTCs in Illinois demonstrates that there is no veto over the licensing of such facilities. And the process of licensing an ASTC is too remote from the decision of a woman to obtain an abortion. As this Court said in *Webster*, "a different analysis might apply" if the imposition of state power in this area ultimately resulted in a *de facto* veto or other undue restriction over abortion choices. *See*, *Webster*, 109 S. Ct. 3040, 3052, fn. 8 and accompanying text.

The state licensing scheme also does not unduly restrict the availability of abortion. It was demonstrated at trial in this case

[64] Except for the previously mentioned two specific requirements, the dissent of Judge Coffey would have viewed the entire statutory and regulatory regime as "abortion neutral," and, therefore, subject only to the requirement that it be rationally related to legitimate state objectives. Although Judge Coffey did not have the benefit of this Court's opinions in *Webster*, his views in review of the Illinois statutes and regulations are consistent with the standards of review set forth by Justice O'Connor in the *Akron* and *Thornburgh* cases, as well as with those of the *Webster* plurality.

that if Dr. Ragsdale's clinic were closed for licensure reasons, there were at least 20 other licensed clinics where an abortion could be obtained, not to mention hospitals performing abortions. 841 F.2d at 1391. The cost of abortion, even assuming *arguendo* the questionable estimated increase advanced by Dr. Ragsdale ($25.21 per abortion) — an increase of only 6-10% — is not significantly greater than the increase in the pathologist's tissue examination approved in *Planned Parenthood* v. *Ashcroft*, 462 U. S. 476, 490 (1983), or, for that matter, certain of the viability tests approved in *Webster*, 109 S.Ct. at 3063 (O'Conner, J., concurring). And it is very likely that the overall *lower* costs of high volume abortions done in ASTCs — assuming no abortions could be performed in unlicensed physician's offices — would probably have the effect of *reducing* the market price of abortion in light of the economies of scale realized in ASTCs. The marginal cost increase, if any, is not large and, in any event, "the State is not required to 'fine-tune' its abortion statutes so as to minimize the costs of abortion." *Akron*, 462 U. S. at 466 (O'Connor, J., dissenting).

As for the mandatory counseling requirement, the State of Illinois is "merely attempting to ensure that the decision to abort is made in light of that knowledge that the [state] deems relevant to informed choice." *Akron*, 462 U. S. at 472 (O'Connor, J., dissenting). The information required to be offered is directly relevant to the woman's choice. It is reasonably related to the State's desire to encourage women to make their choice in favor of natural childbirth. It is not inaccurate or misleading. And far from structuring any physician-patient dialogue, it only supplements it. Such counseling does not pose any severe burden on or obstacle to the abortion decision. But for the extraordinarily abnormal strictures previously imposed by *Roe* in this area, one would have thought it axiomatic that "regulation of the practice of medicine, like regulation of other professions and of economic affairs generally, was a matter peculiarly within the competence of legislatures, and that such regulation was subject to review only for rationality." *Thornburgh*, 476 U. S. at 802 (White, J., dissenting). This is particularly true for state requirements requiring that its citizens be fully informed of the consequences of complicated

surgical procedures that would otherwise be inflicted upon them with little or no knowledge of the risks and consequences.

Finally, the fact that Illinois would require higher standards for the construction, operation and maintenance of its surgical clinics does not have a significant impact on or burden the abortion decision. 841 F.2d at 1394-1396. None of these restrictions can be said to unduly burden a woman's liberty interest in having an abortion. The licensing plan only requires physicians to be more circumspect in equipping and operating surgical clinics in general. Although abortions might, therefore, cost more, the impact of the state action, if any, is on the physician, not the woman desiring an abortion.

In short, none of the Illinois requirements poses a "severe obstacle" or an "absolute veto" to the abortion decision and the statutes and regulations, therefore, need satisfy only the requirement that there be a rational relationship to a legitimate state interest.

2. Rational Basis Test.

Even without the benefit of this Court's *Webster* decision, Judge Coffey would have sustained all but two[65] of the Illinois laws and regulations as reasonably related to legitimate state objectives. His reasoning may be summarized as follows:

> (1) The primary purpose of the ASTCA was to regulate the new cost-effective ASTC's in which semi-complicated (minor) surgery was performed. 841 F.2d at 1386-87.
>
> (2) The ASTCA was intended to regulate *all* minor surgical procedures, including abortion, which expert testimony at trial, as well as *Roe* itself, conclusively demonstrated was a bona fide surgical procedure. 841 F.2d at 1387-88.
>
> (3) A state has not only the power and authority, but also the duty, to regulate medical facilities, particularly any facility where surgical procedures are performed as

[65] The first trimester ASTC or hospitalization requirement and the no financial interest in counseling requirement were found to be defective under *Roe*.

> a valid exercise of protecting health and safety, including that of the mother *and* unborn child, and in so doing, to protect against the many medical and physical risks involved in such procedures. 841 F.2d at 1388.
>
> (4) A state with limited resources may rationally choose to direct its energies to improving the lot of the greatest number and may therefore regulate regular providers of abortion on the same basis as occasional providers when the regulation involves the regulation of the same minor surgical procedures, *citing*, *Williamson* v. *Lee Optical Company*, 348 U. S. 483 (1955); and *Ferguson* v. *Skrupa*, 372 U. S. 726 (1963).

The Illinois licensure provisions thus advance legitimate state objectives and are reasonably related to achieving those objectives.

It may be argued that the requirement that abortions be done only in ASTCs or hospitals is not rationally related to a legitimate state objective since the medical profession considers performance of first trimester abortions in physicians offices to be as safe as those performed in a clinic setting. There is a three-part answer to this argument. First, "[h]ealth-related factors that may legitimately be considered by the State go well-beyond what various medical organizations have to say about the *physical* safety of a particular procedure."[66] The regulation need only have a rational relation to a valid state objective of ensuring the health and welfare of its citizens. *Id.* Moreover, the licensure of an abortionist under Section 16(1) of the Medical Practice Act and its companion provisions in the ASTCA are independently justified by the state's compelling interest in potential human life which applies throughout pregnancy. Although abortion regulation may not have been the primary thrust of the ASTC, the abortion specific provisions indicate a clear state concern that abortions be performed in specialized surgical facilities under special conditions. This was done not only as a matter of cost effectiveness, but also to insure that the interests of the unborn child as well as the woman undergoing an aboriton could be

[66] *Akron*, 462 U. S. at 467 *(O'Connor, J., dissenting)*.

monitored and protected. "The [abortion] decision...has grave consequences for the fetus, whose life the State has a compelling interest to protect and preserve. 'No other [medical] procedure involves the purposeful termination of a potential life.'" *Akron*, 462 U. S. at 474 (O'Connor, J., dissenting). The state has the right, if not the duty, to determine the conditions under which that life can be extinguished, if at all. Finally, despite the asserted safety of first and second trimester abortions, the health risks to the mother from abortion procedures are nevertheless considerable and justify higher medical safety standards. These risks were summarized by Judge Coffey in his dissent:

> Depending upon a particular woman's characteristics and development, medical and psychological problems may very well arise during the abortion procedure that only an experienced, well-trained, board-certified obstetrician and gynecologist is capable of recognizing and effectively treating in a properly designed, constructed, equipped, maintained, managed and medically approved facility. Depending upon the gestational duration of the embryo or fetus, such complications include, but are not limited to, trauma, permanent damage to vital organs, dysfunction of the cardiovascular or respiratory system requiring cardio-pulmonary resuscitation, internal bleeding or hemorrhaging of the uterine wall, cervical lacerations, uterine perforation, embolism of the blood vessels, allergic reaction to medication or anesthesia, if administered, and even the permanent impairment of reproductive organs.

841 F.2d at 1388-1389. Other factors can also produce severe medical complications from performance of an abortion, including sterility, infection and failure to remove the placenta and fetus. *Id.* The fact that only some of these may threaten the woman during the first trimester does not require the state to tailor its medical regulation artificially to the trimester standard. Here, the State has chosen to advance its interests in protecting the unborn and the mother by requiring that abortions be performed by medically competent personnel under conditions insuring maximum safety.

Illinois law also requires that the abortion procedure be described to the woman, that an explanation of the risks and possible complications be given, and that the alternatives to abortion be discussed with the woman undergoing an abortion. This is to be done by a person not having a financial stake in the abortion. These requirements may be questioned as impermissibily interfering with the doctor-patient relationship and structuring that dialogue. The purpose of the requirements is, of course, to provide for informed consent on an *impartial* basis and to notify women of the risks of and alternatives to abortion. The history of abortion, unlike other medical procedures, is not only one involving volume-for-profit,[67] but is characterized by abortionists who frequently withhold important facts about abortion. The counseling requirements were imposed in furtherance of the state's "unquestionably strong and legitimate interest in encouraging normal childbirth" (*Beal* v. *Doe*, 432 U. S. 438, 446 (1977), and to protect women from the obvious financial pulls that characterize a fast-track, volume-for-profit business. To "encourage women to make their choice in favor of childbirth rather than abortion and the provision of accurate information regarding abortion and its alternatives is a reasonable and fair means of achieving that objective." *Thornburgh*, 476 U. S. at 802 (White, J., dissenting); *cf. id.*, 476 U. S. at 830 (O'Connor, J., dissenting).

The first trimester and counseling requirements and all of the other Illinois licensure requirements cannot be viewed in a vacuum. They were part of an overall licensing scheme that furthered a variety of health and safety interests. For example, the ASTCA also requires ASTCs to employ a licensed registered nurse

---

[67] *See* note 6 *supra*. "At least six out of ten abortions performed in the United States are performed in freestanding clinics. Doctors in such clinics typically have a direct financial interest in seeing that abortions are performed as rapidly and efficiently as possible. Frequently, the only time a doctor sees the patient is when she is on the operating table awaiting the procedure." Wood and Durham, *Counseling, Consulting and Consent: Abortion and the Doctor-Patient Relationship*, 1978 B.Y.U.L. Rev. 231,244. Even commentators who support *Roe* admit that "[t]he data fail to support the [fatherly physician-counselor] model portrayed by the [*Roe*] Court." Appleton, *Doctors, Patients and the Constitution: A Theoretical Analysis of the Physicians' Role in Private Reproductive Decisions*, 63 Wash. U. L. Q. 183, 201-202 (1985).

with education or experience in obstetrical or gynecological nursing. It also requires testing and reporting of RH blood factors and diagnosis of pregnancy, and certain reporting of abortion procedures. In addition, ASTCs are subject to the general requirements for surgical centers concerning equipment, policies and procedures, as well as physician control and supervision in cases where the ASTC is a primary provider of abortion. In view of the important state interests in encouraging normal childbirth and in protecting the health and safety of the mother and unborn child, it is not unreasonable for the state to require licensure standards for facilities performing surgical procedures, including abortions. Certainly, these licensure provisions are reasonable and "place no obstacles — absolute or otherwise — in the pregnant woman's path to an abortion." *Maher* v. *Roe*, 432 U. S. 464, 474 (1977).

IV. CONCLUSION

This Court must fashion workable standards to replace the failed regime of *Roe* v. *Wade*. *Roe* has bogged the Federal courts down in a morass of legislative detail that threatens the integrity of the judicial process. It also has contravened "settled principles of constitutional adjudication and procedural fairness,"[68] and gravely threatens important substantive constitutional principles as well.[69]

These dramatic reversals of law are worked solely as a result of this Court's decision in *Roe* which places the abortion decision largely outside the bounds of the law. Unfortunately, as *Roe* and

[68] *Thornburgh*, 476 U. S. at 815 (O'Connor, J. dissenting).

[69] An abbreviated example of the distortion worked by *Roe* may be seen in the exaggerated importance of the physician-patient relationship in the abortion area. The "sancity" of this relationship is now on a level higher than the common law spousal or penitient-priest privilege. But unlike the latter privileges, it is not based on some general rationale that recognizes the value of freedom generally in the relationship where trends in the medical profession suggest the need to regulate in a greater way the provision of information by physicians to their charges. Instead, the sanctity of the physician-patient relationship is limited only to the abortion procedure. Prohibiting state regulation of that relationship clearly "smacks of economic due process rights for physicians" *(Thornburgh*, 476 U.S. at 803 (White, J., dissenting)) and runs directly counter to the long discarded regime of substantive due process that was rejected in the 1930s.

its progency have demonstrated, this "lawlessness" contains the seeds of destruction for all procedural and substantive doctrines that might apply in the abortion area. Once begun, this corrupting influence in the law will not easily be contained.

For its basic error and harm wrought to the rule of law in this country, *Roe* v. *Wade* should be "allowed a deserved repose." *Adkins* v. *Childrens' Hospital*, 261 U. S. 525, 570 (1923) (Holmes, J., dissenting). This Court should return the regulation of abortion to the people and their elected representatives by reversing the judgment of the Court of Appeals and vacating the preliminary injunction.

August 31, 1989.

Respectfully submitted,

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AMICUS CURIAE

BRIEF

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Case No. 88-790

Supreme Court Of The United States

October Term 1989

BERNARD J. TURNOCK, Director of the Illinois Department of Public Health, et al,

Appellant,

vs.

RICHARD M. RAGSDALE, et al.,

Appellee.

On Appeal from
the United States Court of Appeals
For the Seventh Circuit

[redacted]

AND BRIEF OF JAMES JOSEPH LYNCH, JR., AS *AMICUS CURIÆ* IN SUPPORT OF APPELLANT

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QUESTIONS PRESENTED

By *Amicus Curiæ*:

(1) Should *Roe v. Wade*, 410 U.S. 113 (1973) be reconsidered and discarded in favor of finding that a fetus is a member of Posterity, and therefore a person in the Constitutional sense, and thus entitled to the protection of the Constitution?

As framed by the parties (57 LW 3417):

(2) Can Illinois constitutionally license and regulate outpatient surgical facilities in which pregnancy terminations are performed to same extent it licenses and regulates outpatient surgical facilities in which pregnancy terminations are not performed?

(3) Does Case or controversy exist with respect to challenged statutes and regulations that were not being enforced by Illinois prior to filing of complaint?

(4) Are statutes and regulations establishing standards for construction and maintenance and operation of outpatient surgical facilities constitutional as applied to outpatient surgical facilities in which pregnancy terminations are performed?

(5) Can federal courts refuse to give effect to severability requirements, thereby invalidating statutory and regulatory provisions that are constitutional?

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MOTION FOR LEAVE TO FILE *AMICUS CURIÆ* BRIEF*

James Joseph Lynch, Jr., respectfully moves this Court, pursuant to Rule 36, for leave to file the accompanying brief of *amicus curiæ* in support of appellant.**

Amicus is an attorney admitted to practice law in the highest court of the State of California, and a member of the Bar of this Court. He has taken an oath to uphold and defend the Constitution of the United States and to defend the poor,

---

* A table of contents and table of authorities follows at pages (v) and (vii) respectively.

** Illinois has consented to the filing of an *amicus curiæ*. The ACLU has routinely declined to consent, hence it was deemed futile to seek consent in this case.

down trodden, and oppressed. He also presented a similar *Amicus Curiæ* Brief in *Webster v. Reproductive Health Services*, No. 88-605, decided in this court on July 3, 1989, in support of appellant, and has been granted permission to file a similar brief in behalf of one other state.* He is a former professor of Law, University of Northern California, Lorenzo Patiño School of Law. He is affiliated with, but does not represent, a number of pro-life groups and has himself concentrated his practice in the areas of Civil Rights Law, Human Rights Activities, Constitutional Law, and Criminal Defense. He has written and copy righted one article on Abortion entitled *Abortion and Inalienable Rights in American Jurisprudence: A Prospective Policy*. He lived four years in England where he engaged in a self directed study of the English Political System from the inception of the *Magna Carta* (1215). He is a graduate of McGeorge School of Law (1978).

This case touches and concerns the continuing validity of *Roe v. Wade*, and its progeny, and, as such, a decision herein will affect not only the Laws of the State of Ohio, but the State of California wherein *amicus* resides, because it effects the rights of persons residing in California, the liability of the state, and its taxpayers, may, or may not, be liable for damages depending upon the scope of rights belonging to a fetus, which in *amicus*' belief constitutes human life protected by the Constitution. It must be remembered that under Nazi Germany, nearly 9 million innocent lives were lost in a holocaust because no one, at the outset had the courage to say no.** If, as contended here, a fetus is a human life, then

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* *Hodson v. Minnesota*, No. 88-1125 and *Minnesota v. Hodgson*, No. 88-1309, and *Ragsdale v. Turnock*, No. 88-790. Since Webster consented, Ohio's deputy Attorney General is the sole deputy Attorney General to refuse consent.

** It is certain that the atrocities began at least as early as 1938. 6 Enclopedia Britanica 253a (1971). World War II did not start until September 1, 1939, by the Nazi, with United States entry on December 8, 1941 and then only because of events in Hawaii, 22 Id 681b, following.

amicus has an interest as a taxpayer to insure that his state's procedures are neither *contra bono mores*, nor illegal.

Amicus is also concerned about the rights of that class of persons recognized in the Preamble of the Constitution denominated "posterity", and its subclass "fetus" and is concerned, and has been concerned for some time, that fetuses, have been unrepresented or under-represented in any court in the years of litigation which has followed since *Roe v. Wade* was decided in this court in 1973. *Amicus* was convinced then, and remains convinced, that the court was misled as to the meaning of personhood in that arguably a fetus is a member of Posterity found in the Preamble of the Constitution, and that it is imperative, for the preservation of a basic respect for human life, and the values enshrined in the Constitution of the United States that fetuses be recognized as a member of Posterity, but, until *Webster*, due to the inherent nature of our adversary process, has been limited to writing articles concerning the topic.

It is *amicus*' desire, *pro bono publico*, to present to this court, from the fetus' point of view, the rights of the fetus, as it appears to be found in the term Posterity in the Preamble of the Constitution of the United States of America.

Dated: August 28, 1989

Respectfully submitted,

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Table of Contents

QUESTIONS PRESENTED ..... (i)

MOTION FOR LEAVE TO FILE AMICUS CURIÆ BRIEF ..... (ii)

Table of Contents ..... (v)

Table of Authorities ..... (vii)

BRIEF OF JAMES JOSEPH LYNCH, JR., AS AMICUS CURIÆ IN SUPPORT OF APPELLANT 1

INTEREST OF AMICUS CURIÆ 1

STATEMENT OF THE CASE 1

SUMMARY OF ARGUMENT 5

ARGUMENT 6

I *STARE DECISIS* IS LESS BINDING ON THIS COURT ON CONSTITUTIONAL ISSUES EVEN IN THE FACE OF LONG STANDING AND WIDESPREAD PRACTICE 6

II A FETUS IS A PERSON IN THE CONSTITUTIONAL SENSE BY VIRTUE OF THE TERM POSTERITY IN THE PREAMBLE OF THE CONSTITUTION 7

A. Introduction - *Roe v. Wade* Did Not Consider Posterity. 7

B. While the Preamble Does not Create Rights, it does define for Whom the Rights were Created 9

C. The Constitution was Established "By The People" 9

D. The Preamble Creates Two Classes of Persons, on an Equal Footing - "Ourselves" and "Posterity" 11

E. Posterity Was Understood At the Time of Adoption to Include All Future Generations 12

F. That a Fetus was intended as a member of Posterity is Consistent with Common Law Tradition. 13

G. That a Fetus was intended as a member of Posterity is Consistent with the known object and Purposes of the Framers. 14

H. Posterity, including a fetus, has Presently Enforceable Rights 17

I. A fetus is life within the meaning of the 5th Amendment 19

III A STATE HAS AN INTERNATIONAL AND CONSTITUTIONAL OBLIGATION TO PROTECT HUMAN LIFE, AND THEREFORE THE REGULATIONS UNDER SCRUTINY ARE CONSTITUTIONAL 21

CONCLUSION 24

APPENDIX, Excerpts from Farrands, The Constitutional Debates, vol. 2 ..... A1

Table of Authorities

CASES

Adams v. Storey, 1 Paine (U.S.) 79, 1 Fed. Cas. page 141, 145 (1817) 10

Alamo School District v. Jones, 182 Cal.App.2d 180, 6 Cal.Rptr. 272 (1960) 13, 14, 15

Anderson v. United Realty Co., 79 Ohio St. 23, 86 N.E. 644 16

Bank of the United States v. Deveaux, 9 U.S. (5 Cranch) 61, 85 (1809) 10

Barber v. Pittsburgh, F.W. & C.R. Co., 166 U.S. 83, 17 S.Ct. 488, 41 L.Ed. 925 16

Bolling v. Sharpe, 347 U.S. 497 (1954) 6

Bowers v. Hardwick, 478 U.S. 186 (1986) 8, 22

Breckenridge v. Denny, 71 Ky (8 Bush.) 523 12

Brown v. Bd. of Education (*Brown III*), 347 U.S. 483 (1954) 6, 7, 23

Brown v. Bd. of Education, 349 U.S. 289 ..... 7, 23

Brown v. United States, 256 U.S. 335 (1921) 22

Coggs v. Berherd, 2 Ed.Raym. 909 ..... 17, 18

Ex Parte Garland, 4 Wall. 333 (1867) 6

Field v. Clark, 143 U.S. 649, 691 (1891) 6

Flash v. Cohen, 392 U.S.83 19

Furman v. Georgia, 408 U.S. 238 (1972) 21

Gannon v. Albright, 183 Mo. 238, 81 S.W. 1162 16

Gay v. Scates, 37 Pa 31 16

Gibbons v. Ogden, 22 U.S. (9 Weat.) 1 (1824) 10, 11

Haward v. Howe, 12 Gray (Mass.) 49 16

Hertz v. Abrahams, 110 Ga. 707, 36 S.E. 409 16

Hockett v. State Liquor Licensing Board, 110 N.E. 485, 91 Ohio St. 176, L.R.S. 1971B, 7 9

Katz v. United States, 389 U.S. 347 (1967) 22

Knowlton v. Moore, 178 U.S. 87 (1900) 10

Larew v. Larew, 146 Va. 134, 135 S.E. 819 16

Locke v. New Orleans,
71 U.S. (4 Wall) 172 (1866) 10, 11
McIntosh v. Dill, 86 Okla. 1, 205 P. 917 ..... 18 - 20
Mullane v. Central Hanover B&T, 339 U.S. 706
(1950) 19, 20
People v. Emery, 314 Ill. 220, 145 N.E. 349 15
Plessy v. Ferguson, 163 U.S. 537 (1896) 6
Roe v. Wade, 410 U.S. 113 (1973) ..... i, 5, 6, 7, 8, 24
Scott v. Sanford,
60 U.S. (19 How.) 404 (1857) 9, 11, 12, 14
Sinkler v. Kneale, 401 Pa 267,
164 A.2d 93 (1960) 14, 18
United States v. Block, 4 Sawy. (U.S.) 211, 24
Fed.Cas. 14,609 (1877) 10, 11
United States v. Boyer,
85 F.425 (D.C. Mo., 1898) 9
United States v. Classic, 313 U.S. 299, 316 (1941) .....
10
United States v. Cruikshank, 92 U.S. (2 Otto) 542
(1876) 8, 9, 11, 12, 14, 21
United States v. Harris, 1 Abb. (U.S.) 110, 26 Fed.
Ca. No. 15, 312 (1866) 10, 11
Veazie Bank v. Fenno, 75 U.S. (8 Wall) 533, 542
(1869) 10, 11
Webster v. Reproductive Health Services, No. 88-605
(July 3, 1989) ..... (iii), 8
White v. Hart, 80 U.S. (13 Wall.) 646, 650 15
*Witters v. Washington Dept of Social Svcs for the
Blind*, 474 U.S. 481 (1986) 13
Wright v. United States, 302 U.S. 583, 588 (1938) .....
10

CONSTITUTIONS

United States

Preamble 8, 10, A8
Article I, § 2, cl 3 ..... 9, 11

Article I, § 3, cl. 2 16
Art. I, § 8, cl. 17 16
Art. III, § 3, cl. 2 16
Art. IV, § 2, cl. 1 16
Art. VI, cl 2 22
1st Amendment 13
2d Amendment 22
3rd Amendment 16
4th Amendment 16
5th Amendment 8, 16, 19, 21
13th Amendment 9, 11
14th Amendment 8, 9, 11, 21
22nd Amend Section 1 18
22nd Amend Section 2 18

CODES

England

13 Edw. I, c. 1 16
10 Halsbury's Statutes of England (4th Ed)
Constitutional Law, 25 Edw 1 (Magna
Carta)(1297), p. 14, Notes, ¶ 2 21
Statute of De Donis 16
Y.B. 12 Edw. IV, Mich., fo 14 b, pl. 16., fo. 19a,
25 16

MISCELLANEOUS

Acquinas, Summa Theologiæ, 1, q. 76, a. 5 and q.
118, a. 2 13
American Declaration of Independence 15
American Declaration of Independence, ¶ 2 15
American Jurisprudence (2nd), vol. 28,
Estates, § 53 16
Aristotle, Politics, VII, 1335b, 24-26 13
Blackstone at Book IV, p. 198 14
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(1971) 19, 20

Chitty on Contracts (23rd ed, 1968) 134 ..... 17, 18
Colquhounn, Commentaries on the Thames, ix, 284 (1800) 13
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Encyclopaedia Britannica (1971) 14
Farrand, Max, The Constitutional Debates, Vol. 2, pp. 152, 163, 177, 193, 196, 209, 565, 582, 590, 651 ..... 17, A1, et seq.
Foster, Crown Law 273-277 (1762) 22
Exodus, Chap. 21, verse 22 13
Gray, The Rule Against Perpetuities (4th Ed.) 13, 14, 15, 18
Halsbury's Laws of England, vol. 17, (1st ed, 1911), Infants ¶¶ 132, 135 ..... 18, 19, 20
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Johnson, Samuel, "Idler No. 3", p. 5 12
Kings, Book I, verses 1-2 9
Landmark Briefs and Arguments of the Supreme Court of the United States, vol. 75 8
Laqueur, The Human Rights Reader 17
Locke, Second Treatise of Government (1690) 17
Magna Carta (1215), Article 54 ..... 9, 14
McKechnie, Magna Carta 21
Noonan, Contraception, 86-88 (Harv. U. Press,

1965) 13
Oxford English Dictionary, Compact Edition, 1971 ..... 12, 13
Pardoning Power of the President, 5 Opinion U.S. Atty. Gen. 532, 535 (1852) 10, 11
Restatement (2nd) Torts §§ 63, 64, & 65 22
Restatement (1st) Contracts § 77 ..... 17, 18
Rotunda, Treatise on Constitutional Law, vol. 3, § 23.33, p. 512 (1986) 6
Rotunda, Treatises on Constitutional Law, vol. 3, pp. 663-64, note 1 13
Rotunda, vol. 3, op cit, p. 663, note 1 17
Rotunda, vol. 3, op. cit., p. 688, Historical Note 18
Samuel, Book I, verse 16 9
Samuel, Book II, Chap. 5, verse 9-20 9
Schwartz, The Bill of Rights, A documentary history 15
Stephens Commentaries, vol. 2, p. 342 (1841) 18, 19, 20
Verdross, *Forbidden Treaties int'l Law*, 31 AJIL 571 (1937) 17, 21
Verdross, *Jus Dispositivum & Jus Cogens in Int'l Law*, 60 AJIL 55 (1966) 17, 21

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RICHARD M. RAGSDALE, et al.,

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BRIEF OF JAMES JOSEPH LYNCH, JR., AS *AMICUS CURIÆ* IN SUPPORT OF APPELLANT

INTEREST OF *AMICUS CURIÆ*

The Interest of the *Amicus* is set forth *ante* in the Motion for leave to file this brief.

STATEMENT OF THE CASE

Plaintiffs, appellees in this court, consist of a class of all duly licensed physicians and surgeons performing or who desire to perform pregnancy terminations in the State of Illinois and a class of all women in the State of Illinois of child-bearing age who desire or may desire an abortion at

sometime in the future. Defendants, appellants in this court, are a class of the State's Attorneys of all of the counties of the State of Illinois, the Director of the Illinois Department of Public Health, the Illinois Attorney General, and the Director of the Illinois Department of Registration and Education. Plaintiffs sued under 42 U.S.C. § 1983 and 28 U.S.C. §§ 2201-02, seeking declaratory and injunctive relief to the effect that three Illinois statutes and the regulations thereunder violate the constitutional right to privacy, specifically abortion, as established in Roe v. Wade, 410 U.S. 113 (1973), and its progeny. The district court granted a preliminary injunction. The Seventh Circuit vacated some of the claims as moot, and therefore vacated the order with respect thereto, and in all other respects affirmed the preliminary injunction. 841 F.2d 1358, 1360.

The challenged statutes are somewhat complex, but set out in detail at 841 F.2d, at 1360, and in Appellant's Brief. In summary, the statutes under challenge require: (i) revocation and suspension of the licensee of any physician who performs an "elective abortion" in any place other than a licensed Ambulatory Surgical Treatment Center ("ASTC"), a hospital, or a facility run by the state or federal governments; (ii) licensure of all ASTCs; persons applying for lisensure of an ASTC must obtain a certificate of need; (iii) corporate owners of ASTCs to have a licensed physician on its board of directors; (iv) ASTCs to be licensed and pay an initial fee of $500 and a renewal fee each year of $300; (v) ASTCs to be under the supervision of one or more physicians, at least one of whom must have admitting and surgical privileges at a state hospital (vi) ASTCs to file statements of ownership and financial responsibility; (vii) ASTCs to obtain department approval for construction, alteration, or additions to a facility; (viii) ASTCs to submit to quarterly inspections; (ix) that all information concerning a facility received from an ASTC be confidential. 841 F.2d, at 1361 (1988).

An array of remedial enforcement mechanisms exist for

enforcement: (i) a facility may be closed if it constitutes an imminent and serious menace to the health or safety of the patients or if the owner has been convicted for operating an ASTC facility without a license; (ii) a fine of $10,000 per day for operating a facility without a license or any other violation of the Act; (iii) makes operation of a facility in violation of the Act or any regulation thereunder, a public nuisance subject to injunctive relief. The Act is expressly severable. 841 F.2d, 1361-62.

The regulations require, in relevant part: (i) minimum space requirements for procedure and examination rooms; (ii) that ASTC be identifiably separate from other procedural areas; (iii) visual surveillance of traffic entering the operating suite; (iv) separate lounge, lockers, toilets and a place for changing cloths be provided for male and female employees; (v) a separate janitorial closet for the surgical suite; (vi) a diagnostic facility if pre-admission tests are to be performed; (vii) minimum corridor and door width, depending upon whether or not stretchers are to be used; (viii) air-conditioning and ventilation systems with minimum standards. Other parts of the regulations repeat, and provide the details and mechanism, for enforcement of the statutory provisions first mentioned, including disclosures of personnel, and their qualifications, who work for an ASTC, and all persons with an interest in the facility in excess of five percentum. They also require certain public disclosures concerning procedures used and personnel policies, including qualifications. There is a minimum requirement for personnel to be attendant at operations, provisions for laboratory testing, and a consulting committee to establish standards of professional work. Written procedures are required for medical materials and medicines, including storage, garbage and refuse removal, rodent control, maintenance of the ventilation system, and emergency procedures in the event of a non-medical emergency. A complete physical, and specified tests, are required for any procedure which uses a general anaesthesia, or a local anaesthesia with sedation, or for any pregnancy

termination, and a written consent is required for each of the procedures. All removed tissues must be examined by a consulting pathologist.

Post-operative regulations set minimum post-operative observation of the patient where general or special anaesthesia is used, and no patient can be required to leave in less than one hour after the operation, as a means of detecting post-operative complications. The facility must also have a transfer agreement in effect with a hospital within 15 minutes distance, and a staff of the facility must have admitting privileges at such hospital.

The regulations have an abortion specific subpart which require: (i) at least one registered professional nurse with post-graduate education or experience in obstetrical or gynecological nursing; (ii) testing and reporting of the results to the patient of blood Rh factor and diagnosis of pregnancy; and (3) counseling by someone specially trained to give it and who has no financial interest in the patient's decision, which counseling must include a discussion of alternatives, description of the procedure to be performed, and the explanation of the risks and possible complications, and such counseling must be given in an area separate from the procedure room, and a record of the counseling included in the patient's clinical record. Contraception information may be provided post-operatively. Each procedure must be reported on forms provided the department. No abortion may be performed by an ASTC on patients with a gestational age exceeding twelve weeks.

Not all of the regulations are enforced. Since 1981, the Act and regulations have been applied only to facilities which are primarily devoted to the performance of surgical procedures (including abortions). Enforcement of the regulations with respect to second trimester abortions was enjoined pending this court's review of a number of similar challenges in this court. 841 F.2d, at 1363. Other parts of the

regulations have similarly been enjoined by various courts.

Two plaintiffs, Ragsdale and Moe, would either have to cease, or would be unable to provide, abortions because of the necessary public hearing for a certificate of necessity, and the plant physical requirements.

The district court granted injunctive relief as to all aspects of the Act and regulations. The appellate court found that most of the challenged provisions of the Illinois statute were moot because the State agreed it would not enforce the provisions, except as to the reporting requirements, application to those whose practice is "primarily devoted to performing surgery, including first trimester abortions, which was still ripe. 841 F.2d 1364-65, and as to those issues, affirmed the trial court.

SUMMARY OF ARGUMENT

1. This Court has recognized that unconstitutional conduct which has been widespread and in long use cannot stand, and that with respect to the Constitution, *stare decisis* is of less importance than in other cases, and therefore the holding of *Roe v. Wade* is not necessarily binding on this Court, and in fact should be rejected for reasons set forth hereinafter.

2. While the Preamble of the Constitution does not create any rights, it defines for whom the rights were created - Ourselves and Our Posterity, and a construction that Posterity includes fetuses is consistent with the intent of the framers and the common law understanding that a fetus was a person in being, such that a fetus is a person in the Constitutional sense, and because this was not brought to this Court's attention in *Roe v. Wade*, *Roe v. Wade* must be overruled as unsound and contrary to the intent of the framers.

3. Because a fetus is human life and a person in the constitutional sense, and the state has a valid and legitimate right to

protect human life, recognized as an international duty, and imposed as a duty in the Constitution of the United States, the abortion regulations under scrutiny are constitutional for the protection of both the mother and the fetus.

Conclusion. Based upon the foregoing, this court should overrule *Roe v. Wade*, 410 U.S. 113 (1973) prospectively, reverse the decision of the Seventh Circuit at 841 F.2d 1358 as to the constitutionality of the Illinois Statutes and regulations, and remand for further proceedings not inconsistent with this Court's opinion.

ARGUMENT

I

STARE DECISIS IS LESS BINDING ON THIS COURT ON CONSTITUTIONAL ISSUES EVEN IN THE FACE OF LONG STANDING AND WIDESPREAD PRACTICE

Statutes or practices inconsistent with the Constitution, however numerous, can create neither a power which the Constitution does not bestow nor furnish a construction which the Constitution does not warrant. *Field v. Clark*, 143 U.S. 649, 691 (1891); 3 Rotunda, Treatise on Constitutional Law § 23.33, p. 512 (1986). This court, with characteristic good grace, invalidated its own Rules of Court, in part, based on a Congressional Statute requiring attorney's to take an oath with respect to their activities before the civil war, when it was pointed out that the provision was in fact unconstitutional. *Ex Parte Garland*, 4 Wall. 333 (1867). Faced with the Constitutionality of "separate but equal facilities, a practice in existence throughout the south for nearly 60 years, and sanctioned by this Court, this Court overruled, and rightfully so, *Plessy v. Ferguson*, 163 U.S. 537 (1896) in *Brown v. Bd. of Education*, 347 U.S. 483 (1954) (*Brown III*). *Accord*, *Bolling v. Sharpe*, 347 U.S. 497 (1954). Moreover, where the importance of the question is great, and touches sensitive issues

which need to be resolved once and for all, this court has not allowed the fact that some issues were not properly addressed in the courts below from ordering further argument on the omitted issues so that the continuing controversy could be settled. *Brown III*, 347 U.S., at 488-89, 496 (1953); *Brown v. Board of Ed.*, 349 U.S. 289, 294, 298 (Nature of remedy to be utilized).

Such is the case at bench. This court can judicially notice its own docket, which has been impacted by abortion cases. Similarly, it is common news that throughout the country, abortion controversy has led to disorder in the streets.[1]

This court, with the characteristic good grace it exhibited in *Garland*, should now recognize, for reasons which will become apparent hereinafter, that in *Roe v. Wade*, 410 U.S. 113 (1973) it was misled, *overrule* it prospectively,[2] and remand for further proceedings in light of the fact that the fetus is, by virtue of the term Posterity, found in the Preamble of the Constitution, a person in the Constitutional sense.

II

A FETUS IS A PERSON IN THE CONSTITUTIONAL SENSE BY VIRTUE OF THE TERM POSTERITY IN THE PREAMBLE OF THE CONSTITUTION

A. Introduction - *Roe v. Wade* Did Not Consider Pos-

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[1] It is not suggested that the disorder is the reason for overruling Roe. Quite the contrary, the reason is because a fetus is a person in the Constitutional sense by virtue of the term Posterity found in the Preamble. The notation of the problem is put a recognition that the problem must be resolved.

[2] The Seventh Circuit found that certain issues were moot and did not reach them. However, it is evident that Appellants were forced to concede they were foreclosed from enforcing the Statutes and regulations based on decisions relying primarily on *Roe v. Wade*. Therefore, this court should disapprove of all of those cases found at 841 F.2d, at 1364-66 which have held that Illinois cannot enforce its statutes on the same basis, and remand for reconsideration of this Court's opinion, or outright.

terity.

This court in *Roe v. Wade*, 410 U.S. 113 (1973), *held* that a state had no right to regulate abortions in the first trimester of pregnancy in view of the right of privacy of the mother, could provide some regulation in the second trimester, and had the right to full regulation in the third trimester. In reaching this result, the court noted that Texas had failed to demonstrate where in the Constitution the fetus was a person in the Constitutional sense. 410 U.S., at 157-59. A reading of the Petition, Response, and Briefs on the merits by the parties and *amicus* in *Roe v. Wade*, shows that the primary focus of argument was on the term person as found in the 5th and 14th Amendments of the Constitution. 75 Landmark Briefs and Arguments of the Supreme Court of the United State. The opinion itself does not address the Preamble, nor any of the terms found in the preamble.

This court has used the term "posterity" on one prior occasion, *United States v. Cruikshank*, 92 U.S. (2 Otto) 542, 550 (1876), but has never before been called upon to define the term, and to, or for, whom it was intended to include.

In at least one subsequent opinion, this court has held that the right of privacy cannot be used by consenting adults in the privacy of their own bedroom to engaged in homosexual conduct forbidden by State Law. *Bowers v. Hardwick*, 478 U.S. 186 (1986). There is no case that has ever reported that a female, based on her right to privacy, can do whatever she wishes with her body, including acts of prostitution in the privacy of her own bedroom in violation of state law. *A fortiori*, if the fetus is a person in the Constitutional sense, it does not seem reasonably possible that a woman can, absent justification or excuse of taking the life of a fetus in violation of state law.

This court, just this term, *Webster v. Reproductive Health Services*, 88-605 (July 3, 1989), held that the statutes therein

which withheld public funds, employees, and facilities from use in non-therapeutic abortions did not offend the Constitution. In doing so, it was noted that the decision all but wipes *Roe* off the books as an unconditional right to an abortion. Id, slip opinion, concurring Opinion of Scalia, J., p. 1.

B. While the Preamble Does not Create Rights, it does define for Whom the Rights were Created

The Preamble's true office is to expound the nature and extent and application of the powers actually conferred by the Constitution, and not substantively to create them. *United States v. Boyer*, 85 F.425 (D.C., Mo., 1898) (Quoting Mr. Justice Storey on the Constitution, Section 462). *Cf., Hockett v. State Liquor Licensing Board*, 110 N.E. 485, 91 Ohio St. 176, L.R.S. 1971B, 7. That aside, it does define for whom the constitution was created, and where sovereignty resides. *Scott v. Sanford*, 60 U.S. (19 How.) 404 (1857);[3] *Cruikshank, supra*, 92 U.S. (2 Otto), at 549.

C. The Constitution was Established "By The People"[4]

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[3] The 13th & 14th Amendments do not overrule this proposition. Rather, they redefine citizen (See, Article I, § 2, cl 3; § 9, cl. 1), and thus enlarge the class of persons who are citizens.

[4] Recorded history first notes that a sovereign rules with the consent of the governed in I Sam. 16, II Sam. 5, 9-20, I Kings 1-2. There, David as a youth was anointed as the successor to Jesse, his father. When his father died, he ruled over the seven tribes of Judah for seven years. At that time, when the rest of Israel were doing poorly, they noted that Judah prospered under David, so they asked that he rule them as well. Thereafter David ruled over all of Israel and Judah for forty years. But there is nothing to indicate the right to rule was in writing. Other codes, most notably the Code of Hammurabi, were in writing, but were unilateral acknowledgments of human rights. Thus, the *Magna Carta*, *infra*, appears to be the first written document executed by both the sovereign and its subjects. The U.S. Constitution abolished traditional concepts of sovereignty, placed sovereignty in the People, signed by their representative, and ratified by them according to their respective state procedures. *Infra*.

The Constitution,[5] in the Preamble, declares that "We the People" do ordain and establish this Constitution. "Here, in strictness, the people surrender nothing; and as they retain every thing they have no need of particular reservation, 'We, THE PEOPLE of the United States, to secure the blessings of liberty to ourselves and our posterity, do ordain and establish this Constitution for the United States of America.' Here is a better recognition of popular rights than volumes of those aphorisms which make the principle figure in several of our State bills of rights and which would sound much better in a treatise of ethics than a constitution of government." Hamilton, The Federalist Papers, No. 84.; Preamble, *Amicus* Appendix, p. A8.

The words "people of the United States" and "citizens" are synonymous terms, and mean the same thing. They both describe the political body who, according to our republican institutions, form the sovereignty, and who hold power and conduct the government through their representatives. They are what we familiarly call the "sovereign people" and every citi-

[5] In the solution of constitutional questions the same rule of interpretation, and sources of judicial information, may be resorted to as in the construction of statutes and other instruments granting power. *Adams v. Storey*, 1 Paine (U.S.) 79, 1 Fed. Cas. page 141, 145 (1817). The constitution and the law are to be expounded without leaning one way or the other, according to those general principles which usually govern the construction of fundamental or other laws. *Bank of the United States v. Deveaux*, 9 U.S. (5 Cranch) 61, 85 (1809). No word or clause can be rejected as superfluous or unmeaning, but each must be given its due force and appropriate meaning. *Wright v. United States*, 302 U.S. 583, 588 (1938); *Knowlton v. Moore*, 178 U.S. 87 (1900). Words and terms are to be taken in the sense they were used and understood at common law and at the time the constitution and the amendment were adopted. *Veazie Bank v. Fenno*, 75 U.S. (8 Wall.) 533, 542 (1869); *Locke v. New Orleans*, 71 U.S. (4 Wall.) 172 (1866); *Gibbons v. Ogden*, 22 U.S. (9 Weat.) 1, 188-189 (1824); *United States v. Harris*, 1 Abb. (U.S.) 110, 26 Fed. Ca. No. 15, 312 (1866); *United States v. Block*, 4 Sawy. (U.S.) 211, 24 Fed.Cas. 14,609 (1877); Pardoning Power of the President, 5 Opinion U.S. Atty. Gen. 532, 535 (1852). Where there are several possible meanings of the words of the constitution, that meaning which will defeat rather than effectuate the constitutional purpose cannot rightly be preferred. *United States v. Classic*, 313 U.S. 299, 316 (1941).

zen is one of these people, and constituent member of this sovereignty. *Scott v. Sanford*, 60 U.S. (19 How.) 404 (1857);[6] *Cruikshank, supra*, 92 U.S. (2 Otto), at 549.

D. The Preamble Creates Two Classes of Persons, on an Equal Footing - "Ourselves" and "Posterity"

There being no debate, and the question of the meaning "to ourselves and our Posterity" being one of first blush, we must turn to the meaning commonly understood at the time of the adoption to determine its extent and application. *Veazie Bank v. Fenno*, 75 U.S. (8 Wall) 533, 542 (1869); *Locke v. New Orleans*, 71 U.S. (4 Wall) 172 (1866); *Gibbons v. Ogden*, 22 U.S. (9 Weat.) 1, 188-189 (1824); *United States v. Harris*, 1 Abb. (U.S.) 110, 26 Fed. Ca. No. 15, 312 (1866); *United States v. Block*, 4 Sawy. (U.S.) 211, 24 Fed.Cas. 14,609 (1877); Pardoning Power of the President, 5 Opinion U.S. Atty. Gen. 532, 535 (1852).

The phrase in question begins with the preposition "to". As so used, it marks the object for which the purposes were secured. Webster's Dictionary of the English Language, 1968.

"Ourselves" is a pronoun, the plural of "ourself", and when used in the objective, as here, it simply serves as the reflexive pronoun corresponding to "we" or "us". *Ibid.* "We", in this case, appears at the beginning of the preamble and is defined by the parenthetical statement immediately following "the People of the United States." "Ourselves" is therefore synonymous with "the people of the United States" and hence also "citizen". *Scott v. Sanford, supra*, 60 U.S. (19 How.) 404; *Cruikshank, supra*, 92 U.S. (2 Otto), at 549.

"And" is 'a particle joining words and sentences, and ex-

[6] The 13th & 14th Amendments do not overrule this proposition. Rather, they redefine citizen (See, Article I, § 2, cl 3; § 9, cl. 1), and thus enlarge the class of persons who are citizens.

pressing the relations of connection or addition. Webster's, op. cit. In this case, its purpose is to add to the object for which the purposes were secured. "Our" means of, or belonging to, "us", i.e., to the speaker (in this case "We, the People of the United States), or to the speaker and the person or persons whom he speaks for or includes. It is a possessive adjective corresponding to "We", "Us"; expressing the genitive of possession; also, the objective genitive, as in "our defense", "our Maker", "our persecutors". Oxford English Dictionary, Compact Edition, 1971. (Hereinafter, OED). Its purpose is to include "Posterity" on an equal footing with, and the same rights as, "our selves" as evidenced by the parallel structure of the phrase. Therefore, "posterity" is synonymous with "citizen". *Scott v. Sanford*, *supra*, 60 U.S. (19 How.) 404; *Cruikshank*, *supra*, 92 U.S. (2 Otto), at 549.

E. Posterity Was Understood At the Time of Adoption to Include All Future Generations

Posterity, as it appears in the Preamble, has not been defined by the Supreme Court, therefore we must turn to what the framer's understood it to mean at the time the constitution was adopted in 1789. *Ante*, footnote 3, and the citations therein.

"Posterity", at the time of the Framers, was defined as "1. The descendants collectively of any person; all who have proceeded from a common ancestor. 2.+a. A later generation (with plural). obs. b. All succeeding generations (collectively)." OED, op. cit. *Accord, Breckenridge v. Denny*, 71 Ky (8 Bush.) 523.

The Preamble is not concerned with an individual in particular, as in 1. Nor in the sense of 2.a, which in any event is obsolete. 2b appears to be the sense which the framers had in mind. Samuel Johnson, "Idler No. 3", p. 5, used it in that sense in 1758 when he wrote, "The Ocean and sun will last our time, and we may leave posterity to shift for themselves." It was

again used in that sense by Colquhounn in Commentaries on the Thames, ix, 284 when he wrote in 1800 "They will deserve the Thanks of the Nation, and the gratitude of Posterity." OED, op. cit.

The Constitution was signed on September 17, 1787, and Congress on February 18, 1791 formally recognized that the states had ratified the Constitution and therefore it was in effect. 3 Rotunda, Treatises on Constitutional Law, pp. 663-64, note 1. Thus it may be assumed the same sense was intended. *Ante*, footnote 3, and the citations therein.

F. That a Fetus was intended as a member of Posterity is Consistent with Common Law Tradition.

The Framers used the term Posterity without qualification. In 1644, in a well known pamphlet, it was argued that Parliament can no more censure the issue of the mind than it can the issue of the womb." Milton, John, "Aeropagitica" (1644).[7] At common law, it was understood that certain members of future generations, fetuses,[8] were a life in being for the purposes of the Rule Against Perpetuities. Gray, The Rule Against Perpetuities (4th Ed.); *Alamo School District v. Jones*, 182 Cal.App.2d 180, 6 Cal.Rptr. 272 (1960). Moreover, prenatal injuries, were to a limited extent, recognized at Common Law. "To kill a child in its mother's womb is now no murder,

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[7] Milton went on to observe that he did not believe that his remarks applied to Catholics. While this Catholic takes exception to the exception, his premise appears sound in all other respects. It may be that today he would have different feelings on the matter.

[8] That a fetal has rights was probably recognized as early as 322 BC at least. Aristotle, *Politics*, VII, 1335b, 24-26; Acquinas, *Summa Theologiæ*, I, q. 76, a. 5 and q. 118, a. 2; Noonan, Contraception, 86-88 (Harv. U. Press, 1965). The Old Testament provided a remedy for anyone causing a miscarriage. 21 Exodus 22. It does not offend the Establishment Clause of the 1st Amendment merely because civil enforcement corresponds to the tenants of some religious beliefs. *Generally, Witters v. Washington Dept of Social Svcs for the Blind*, 474 U.S. 481 (1986).

but a great misprision: but if the child be born alive and death by reason of the potion or bruises it received in the womb, it is murder in such as administered or gave them." Lord Coke, repeated by Blackstone at Book IV, p. 198.[9] And common law does not appear to have barred tort actions for prenatal injuries. *Sinkler v. Kneale*, 401 Pa 267, 164 A.2d 93, 94 (1960).

It thus appears that the framer's intended that "All succeeding generations (collectively)" include common law concepts of the rights of a fetus and to be synonymous with "citizen". *Scott v. Sanford*, *supra*, 60 U.S. (19 How.) 404; *Cruikshank*, *supra*, 92 U.S. (2 Otto), at 549.

G. That a Fetus was intended as a member of Posterity is Consistent with the known object and Purposes of the Framers.

As the Preamble appears to confer rights upon "posterity" equal to "our selves", it is necessary to determine whether the framer's[10] intended that the rights be vested. Ante, footnote 3, and the cites therein. One measure of intent would be to determine whether vesting has occurred for the purpose of the rule against perpetuities. Gray, The Rule Against Perpetuities (4th Ed.); *Alamo School District v. Jones*, 182

[9] Lord Coke's rationale rested on the impossibility of determining when life began, hence there would always be reasonable doubt as to whether or not murder had been committed. Two reasons may be advanced for that. First, at common law, "No man shall be taken or imprisoned upon the appeal of a woman, for the death of any other than her husband." *Magna Carta* (1215), Article 54. Thus, a failure of evidence. Second, medical knowledge as to the status of a fetus was quite primitive when compared to modern medical practices.

[10] Of the 39 signers of the constitution, at least 8 were lawyers (of which one studied at the Middle Temple in London England and another studied law in England), two more appear to have studies law extensively (Chs. C. Pinchkney at the Middle Temple in London, England), and two more were, or became, judges. Generally, Encyclopaedia Britannica (1971) (Comparison with signers Volume 22, p. 695, with their biographies.). Hence it is fair to assume that the framer's were not unaware of what they were doing, and how to secure that which they wished to do.

Cal.App.2d 180, 6 Cal.Rptr. 272 (1960).

Had the framers used "and our heirs", it would have created the equivalent of a fee simple absolute with the powers of alienation. But such a concept would have been inconsistent with the concept of "unalienable rights" found in the Declaration of Independence[11] and the concept of an "indestructible and perpetual union." *White v. Hart*, 80 U.S. (13 Wall.) 646, 650. Therefore, the framer's must have had a different intent in mind when they used "Posterity."

If "Posterity" is to be viewed as conferring a contingent remainder to a class, then it must fail for being obnoxious to the rule against perpetuities because there would be members of the class capable of taking more than 21 years, plus the gestation period, after lives in being. Gray, The Rule Against Perpetuities (4th Ed.); *Alamo School District v. Jones*, 182 Cal.App.2d 180, 6 Cal.Rptr. 272 (1960). But if void, then it would create a fee simple absolute in the present generation, thus, once again, frustrating the intent of the framer's in creating "unalienable rights" and a "perpetual union". Therefore, another meaning consistent with the framer's intent must be found. *Ante*, footnote 3, and the citations therein.

Under the rule in Shelly's Case, a limitation of an estate to an ancestor for life, with the remainder to his heirs or the heirs of his body, gave the whole estate in fee to the ancestor. 31 *Corpus Juris Secundum*, Estates § 4. This rule applies only where the estate in freehold and the estate in remainder are created by the same instrument as in the Preamble. *People v. Emery*, 314 Ill. 220, 145 N.E. 349; 69 C.J.S. p. 512, note 77.

[11] American Declaration of Independence; Schwartz, The Bill of Rights, A documentary history. The Declaration states, in relevant part: "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain **unalienable** Rights, that among these rights, Government are instituted among Men, deriving their just powers from the consent of the governed, ..." American Declaration of Independence, ¶ 2.

Again, because this is inconsistent with the known intent of the framers, another meaning must be found. *Ante*, footnote 3, and the citations therein.

An estate tail may, under certain circumstances, be created or arise by implication. *Hertz v. Abrahams*, 110 Ga. 707, 36 S.E. 409; *Haward v. Howe*, 12 Gray (Mass.) 49; *Gannon v. Albright*, 183 Mo. 238, 81 S.W. 1162; *Gay v. Scates*, 37 Pa 31; *Larew v. Larew*, 146 Va. 134, 135 S.E. 819. Such a situation commonly arises if a conveyance[12] or devise in fee has been made to some particular person named without issue, upon an indefinite failure of issue. In other words, whenever it appears in the instrument creating the estate that it was intended that the issue of the first taker should take by inheritance in a direct line, and in a regular order and course of decent, so long as his posterity should endure, and an estate in fee or in tail is given in remainder upon an indefinite failure of issue, then the estate first created will be construed to be an estate tail, or fee tail. 28 American *Jurisprudence*, Second, Estates, § 53. *Cf., Barber v. Pittsburgh, F.W. & C.R. Co.*, 166 U.S. 83, 17 S.Ct. 488, 41 L.Ed. 925; *Anderson v. United Realty Co.*, 79 Ohio St. 23, 86 N.E. 644, affmd 222 U.S. 164 (recognizing by *dictum* that this rule was followed at common law).

The Statute of De Donis[13] made fee tails unalienable by using the words "to A and the heirs of his body." In 1472, Taltarum's Case virtually abolished tails for most purposes. Y.B. 12 Edw. IV, Mich., fo 14 b, pl, fo 19a, 25. An estate in tail was not subject to The Rule Against Perpetuities because it was a present future interest. See, 13 Edw. I, c. 1; Y.B. 12 Edw. IV,

[12] The Constitution expressly concerns estates and interests in lands. See, Art. I, § 8, cl. 17 (District of Columbia; Places purchased); Art. III, § 3, cl. 2 (forfeitures); Art. IV, § 2, cl. 1 (privileges and immunities), § 3, cl. 2 (property belonging to the United States; Amendment III (Quartering of soldiers); Amend IV (Secure in their persons, houses);Amend V (nor be deprived of ... property without due process of law; nor shall private property be taken for public use without just compensation ....).

[13] 13 Edw. I, c. 1.

Mich., fo 14 b, pl. 16., fo. 19a, 25. Hence it is reasonable to infer that in lieu of the common law formulation the framers chose "to ourselves and our Posterity" to effectuate their intent that the "first takers should take by inheritance in a direct line, and in a regular order and course of decent, so long as his posterity should endure". This construction would carry out and effectuate the intent of the framers that the rights conferred be "unalienable", and to create a perpetual union. *Ante*, footnote 3, and the citations therein.

II. Posterity, including a fetus, has Presently Enforceable Rights

There are three points in time when one could cross the threshold of being "our selves" (present interest) from "posterity" (Presently enforceable future interests): conception; at birth; at age of capacity. Chitty on Contracts (23rd ed, 1968) 134; Restatement of Contracts (1st) § 77; *Coggs v. Berherd*, 2 Ed.Raym. 909.

Implicit in the Preamble is the concept that the Constitution is to be a social contract. Eg. Hobb, Leviathan (1651); Locke, Second Treatise of Government (1690); Laqueur, The Human Rights Reader. It was submitted to the People for ratification. 2 Farrand, Max, The Constitutional Debates, pp. 152, 163, 177, 193, 196, 209, 565, 582, 590, 651; Amicus Appendix. 3 Rotunda, op cit, p. 663, note 1. Thus it is implicit that acceptance could only be by those not suffering from a disability, ie., persons with the capacity to consent. R. Edge, "Voidability of Minor's Contracts: A Feudal Doctrine in a Modern Economy," 1 G.L.Rev. 205 (1967). Viewed as a social contract, the Individual in general promises the individual in particular to secure for him inalienable rights, in return for which the individual promises to conform to the laws of the majority which do not derogate[14] from the promise

[14] Verdross, *Forbidden Treaties int'l Law*, 31 AJIL 571 (1937); *Id, Jus Dispositivum & Jus Cogens in Int'l Law, 60 AJIL 55 (1966);*

of inalienable rights. Such mutual promises have always been considered sufficient consideration for enforceability. Chitty on Contracts (23rd ed, 1968) 134; Restatement of Contracts (1st) § 77; *Cogge v. Berhend*, 2 Ed.Raym. 909.

As persons who have not reached the age of capacity[15] could not consent, Chitty, op. cit., it would appear that adults are of the class "our selves," and all others of the class "Posterity."

At common law, with few exceptions, the tenant in possession of a fee tail could be enjoined from alienation by those with a right to inherit. Moreover, a *guardian ad litem*, a guardian appointed by a court, could prosecute or defend for an infant in any suit to which he may be a part, 2 Stephens Commentaries 342 (1841), or by the State acting in *Parens patriae*. *McIntosh v. Dill*, 86 Okla. 1, 205 P. 917, 925; 17 Halbury's Laws of England (1st ed, 1911), Infants ¶¶ 132, 135. Thus, it is clear that at common law that at least those members of Posterity who were born had a presently enforceable right.

Turning to whether a fetus, as a member of Posterity, had a common law protectable interest, it appears in the affirmative. As already noted, ante p. 10-11 citing Lord Coke, while it is was not murder to kill a child in a mother's womb, it was still a misprision (crime)!. The unborn was a life in being for purposes of the rule against perpetuities. Gray, op.cit. Moreover, it does not appear that common law barred tort ac-

[15] The 22nd Amendment provides: "Section 1. The right of citizens of the United States, who are eighteen years of age or older, to vote shall not be denied or abridged by the United States or by any State on account of age. Section 2. The Congress shall have the power to enforce this article by appropriate legislation." Arguably, without this provision, any "person born in the United States or under its jurisdiction" is a citizen, and could vote regardless of age. In practice, age was regulated by the States, and it was understood to be the common law age of maturity, unless modified by the respective states. 3 Rotunda, op. cit., p. 688, Historical Note.

tions for prenatal injuries, *Sinkler v. Kneale*, *supra*, 164 A.2d 93, 94 (1960), which could be brought by a representative. 2 Stephens Commentaries 342 (1841); *McIntosh v. Dill*, *supra*, 205 P. 917; 17 Halbury's Laws of England (1st ed, 1911) Infants ¶¶ 132, 135.

It thus appears that in view of the known object and intent of the framer's that they intended to create unalienable rights and a perpetual union, knew of the common law rights of the unborn, and chose Posterity without limitation to include within the class of persons protected the unborn conceived fetus.

I. A fetus is life within the meaning of the 5th Amendment

The Constitution provides, in relevant part:

> "No person shall be, ... deprived of life ... without due process of law."

U.S. Constitution, 5th Amendment. Neither a State nor the federal government may utilize money to take life without due process of law. *Eg, Flash v. Cohen*, 392 U.S.83, 88 S.Ct. 1942, 20 L.Ed.2d 947 (1968). Assuming, *arguendo*, that the fetus is a life, it has the right to representation, 2 Stephens Commentaries 342 (1841); *McIntosh v. Dill*, *supra*, 205 P. 917; 17 Halbury's Laws of England (1st ed, 1911) Infants ¶¶ 132, 135, to be heard on the question as to whether its life should be terminated. *Generally, Mullane v. Central Hanover B&T*, 339 U.S. 706 (1950).

It would appear that a fetus has all of the characteristics of life:[16] excretion,[17] ingestion,[18] respiration,[19] irritation,[20] and re-

[16] Biology: Observation & Concept by Case & Steirs (1971), p. 110.

[17] Id, pp. 122, 141, 143, 149-150.

[18] Id, pp. 70, 80.

production.[21] A zygote (early fetus) is viable, in contradistinction to the ovum and sperm which are not.[22] Whether or not it can be ascertained at any point in time that it is human is an absurd proposition; assuming it goes to term it cannot be anything but human. The fact that the zygote is not viable extrauterine does not negate the fact of life. Life exists in an environment. No one would seriously consider sending an astronaut tied to an "umbilical cord" on a space walk to test whether or not the astronaut were life by cutting the umbilical cord to see if the astronaut could survive; such a proposition is absurd. Moreover, even a fetus securely within the womb will die if there is an abruption of the placenta.[23] Finally, the courts can judicially notice the advance of science in making possible test tube pregnancies, and transfers from one womb to another, all suggesting the presence of life from conception.

The terms "ensoulment", "psych", "free will", and when they manifest themselves, are not relevant. We are concerned with Posterity, and it cannot be denied, in light of the arguments heretofore made, that Posterity includes all future generation, with the conceived having a presently protectable interest. 2 Stephens Commentaries 342 (1841); *McIntosh v. Dill*, *supra*, 205 P. 917; 17 Halbury's Laws of England (1st ed, 1911) Infants ¶¶ 132, 135.

Therefore, the fetus is a life which may not be taken without due process of law, and a compelling, legitimate governmental interest.[24] *Generally, Mullane v. Central*

[19] Id, pp. 8, 51, 64, 77.

[20] Id, irritation, pp. 267, 329, 330;.

[21] Id, reproduction, pp. 122, 163-165, 298-299, 327, 329;.

[22] Id, pp. 324-327.

[23] Jacobs, Warren M. and Jacobs Mark A., MDs, Obstetrics and Gynecology, Family Health & Medical Guide (1979), page 93;.

[24] Because a fetus is a person, the State has an interest in protecting

Hanover B&T, 339 U.S. 706 (1950).

III

A STATE HAS AN INTERNATIONAL AND CONSTITUTIONAL OBLIGATION TO PROTECT HUMAN LIFE, AND THEREFORE THE REGULATIONS UNDER SCRUTINY ARE CONSTITUTIONAL

Under International Law, a State has the obligation to provide police protection of its citizens at home. Verdross, *Forbidden Treaties int'l Law*, 31 AJIL 571 (1937); *Id, Jus Dispositivum & Jus Cogens in Int'l Law*, 60 AJIL 55 (1966). The concept to protect a person from due process in American Jurisprudence is derived from the *Magna Carta* (1215). McKechnie,[25] *Magna Carta*; the Great Charter of King John. The 5th Amendment prohibits the taking of life without due process of law, and it is enforced and made binding against the states by the 14th Amendment. *Generally, Furman v. Georgia*, 408 U.S. 238 (1972), and it *progeny*; *Cruikshank*, *supra*, 92 U.S. (2 Otto), at 549.

Given a state's obligation to protect it citizens at home, and to ensure life is not taken without due process of law, Ohio has a legitimate interest in providing for the protection of fetal life. It's citizens, and the citizen's of every state has an interest in insuring that there exists safeguards to insure that abortion does not become a tool for genocide. Eg, International Convention on the Prevention and Punishment of the Crime of Genocide, Congressional Digest, December

that life, and it therefore becomes a balancing test weighing the interest of the mother against that of the fetus. It would appear then that the life of the fetus could be terminated only if it threatens the life of the mother, because other alternatives are now available such as transferring the zygote to the womb of a willing carrier or mother.

[25] McKechnie is the recognized scholar on the *Magna Carta*. 10 Halsbury's Statutes of England (4th Ed) Constitutional Law, 25 Edw 1 (*Magna Carta*)(1297), p. 14, Notes, ¶ 2.

1984; U.S. Const., Art. VI, cl 2 (treaties).

This is not to say that a State may say a woman does not have any right to privacy and may never have an abortion. Clearly, the Constitution implicitly recognizes the right to privacy. U.S. Const., 2d (Quartering of soldiers), and 4th (search and seizure) Amendments; *Katz v. United States*, 389 U.S. 347 (1967), and its *progeny*. But it is equally clear that a person cannot use the right of privacy and the right to do with one's body what he or she wishes to do with their body if the conduct amounts, under state law, to a crime. *Bowers v. Hardwick*, 478 U.S. 186 (1986). Nonetheless, every person has the right to self defense. Foster, Crown Law 273-277 (1762); Restatement (2nd) Torts §§ 63, 64, & 65; *Brown v. United States*, 256 U.S. 335 (1921). Thus it would appear where the woman's life or health is endangered, termination of the pregnancy would be justified. But even here, there appears to be less drastic alternative means than outright abortion. This court can judicially notice, or remand for consideration, the fact that modern advances have made possible womb to womb transfers to embryos. On the same basis, this court may notice or remand the fact that there are many persons unable to conceive who would welcome such transfers.

The statutes under scrutiny ensure that the facilities are medically clean and sound[26] for the protection of both the expectant mother, and the fetus, should it be viable, or a uterine to uterine transfer for the preservation of life be feasible and desirable. If, as set forth ante, a fetus is a person in the constitutional sense, then counseling is appropriate by a

[26] It is difficult to fathom plaintiffs' logic. One of the primary arguments for *Roe v. Wade* was that it would take such procedures out of the back room where poor and unsanitary procedures are used which was killing countless millions of women yearly, and put such operations in a safe and clean environment for the expectant mother's protection. Yet when Illinois has provided the safe environment, they scream for a return to the unsanitary facilities which *Roe v. Wade* was initially designed to eradicate!

detached person who can point to less drastic measures available, including such things as adoption, or uterine to uterine transfer to a woman who cannot conceive, but can carry the fetus. Even if this court is not persuaded to overrule *Roe v. Wade*, such counseling is nevertheless required because the potential post-operative impact upon the psychological condition of the expectant mother in terminating a the life of a fetus which might not be appreciated by the uninformed. Stated otherwise, it is common medical practice to obtain informed medical consent of a patient in any event. 3 Lane Medical Litigation Guide §§ 40.35, et seq. Given the general, non-discriminatory, requirement of informed consent, it is a legitimate tool of Illinois that such a controversial, and potentially devastating procedure on the mental health of its victims, that the consent they give is truly informed and intelligent.

Some of the plant requirements, such as hallways and doors, just make common sense: in the event of an emergency during a procedure, how is the patient to be removed? Can a stretcher get the patient out safely and in time? Surely, these consideration need to be thought about for the safety of the consuming public, and therefore Illinois is quite right in insisting on these minimum safety requirements.

Based on the foregoing, Illinois' statutes and regulations which do nothing more than to insure properly qualified personnel, and a safe place is a legitimate governmental function imposed by international law and the U.S. Constitution. It does not absolutely bar abortions, but does insure that life is not arbitrarily taken,[27] and it furthers the state interest in protecting expectant mothers from

[27] Indeed, arguably Illinois, misled no doubt by *Roe*, has not gone far enough in the protection of fetal life because it allows the taking of the fetal life without any hearing whatsoever. But that issue is not now before the court, although under *Brown I* and *Brown II*, this Court could, land probably should, consider that issue as well.

substandard care.

CONCLUSION

Based upon the foregoing, this court should overrule *Roe v. Wade*, 410 U.S. 113 (1973) prospectively, reverse the decision of the Seventh Circuit at 841 F.2d 1358 as to the constitutionality of the Illinois Statutes and regulations, and remand for further proceedings not inconsistent with this Court's opinion.

Dated: August 27, 1989

Respectfully submitted,

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EXCERPTS FROM

2 Farrand, Max, The Constitutional Debates*

[129]

COMMITTEE OF DETAIL, I

***

[Proceedings of the Convention, June 19 -- July 23.]

[152]

COMMITTEE OF DETAIL, IV

*****

VI

We the People of (*and*) the States of New Hampshire, Massachusetts, Rhode Island and Providence Plantations, Connecticut, New. York, New. Jersey, Pennsylvania, Delaware, Maryland, Virginia, North. Carolina, South. Carolina and Georgia do ordain declare and establish the following Constitution for the Government of ourselves and of our Posterity.

* Pages from Farrand's are indicated at the beginning of the page in [ ]. All punctuation and capitalization is exactly as found in Farrand's which faithfully follows the manuscript originals in Madison's book. All footnotes were omitted unless deemed important to the issues under consideration. The most commonly omitted footnote says "Found among the Wilson Papers and in Wilson's handwriting. Portions in parentheses represent parts crossed out. Italics represent later insertions."

1.

*****

[163]

COMMITTEE OF DETAIL, IX

*****

IX

We the People of the States of New Hampshire, Massachusetts, Rhode-Island and Providence Plantations, Connecticut, New-York, New-Jersey, Pennsylvania, Delaware, Maryland, Virginia, North-Carolina, South-Carolina and Georgia do ordain, declare and establish the following Constitution for the Government of ourselves and our Posterity.

1.

*****

[177]

Monday MADISON August 6

MADISON

Monday August 6th. In Convention

<Mr. John Francis Mercer from Maryland took his seat.>

Mr. Rutlidge <delivered in> the Report of the Committee of detail as follows: < a printed copy being at the

same time furnished to each member.>

We the people of the States of New Hampshire, Massachusetts, Rhode-Island and Providence Plantations, Connecticut, New-York, New-Jersey, Pennsylvania, Delaware, Maryland, Virginia, North-Carolina, South-Carolina and Georgia do ordain, declare, and establish the following Constitution for the Government of Ourselves and our Posterity.

Article I

****

[193]

TUESDAY, AUGUST 7, 1787.

JOURNAL

• Tuesday August 7. 1787.

[To refer the report to a Committee of the whole Ayes -- 5; noes -- 4.

Delaware being represented during the Debate a question was again taken on ye Committee of ye whole Ayes --- 3; noes --- 6.]

On the question to agree to the Preamble to the constitution as reported from the committee to whom were referred the Proceedings of the Convention -- it was passed unan: in the affirmative [Ayes -- 10; noes --- 0.]

*****

MADISON

Teusday August 7th. In Convention

The Report of the Committee <of detail being> taken up.

***

The <preamble> of the Report was agreed to nem. con. So were Art: I & II.

*****

MCHENRY

Augt. 7.

*****

The preamble or caption and the 1. and 2. article passed without debate, ...

*****

COMMITTEE OF STYLE

Proceedings of Convention Referred to the Committee of Style and Arrangement.

We the People of the States of New-Hampshire, Massachusetts, Rhode-Island and Providence Plantations, Connecticut, New-York, New-Jersey, Pennsylvania, Delaware, Maryland, Virginia, North-Carolina, South-Carolina and Georgia do ordain, declare and establish the following Constitution for the Government of ourselves and our Posterity.

ARTICLE I.

*****

COMMITTEE OF STYLE

Report of Committee of Style

WE, the People of the United States, in order to form

a more perfect union, to establish justice, insure domestic tranquility, provide for the common defense, promote the general welfare, and secure the blessings of liberty to ourselves and our posterity, do ordain and establish this Constitution for the United States of America.

ARTICLE I.

*****

[604]

THURSDAY, SEPTEMBER 13, 1787.

JOURNAL

Thursday September 13, 1787.

* * * *

Resolved that the preceding Constitution be laid before the United States in Congress assembled,and that it is the opinion of this Convention that it should afterwards be submitted to a Convention of Delegates, chosen in each State by the People thereof, under the recommendation of it's Legislature; for their asent and ratification. * * *

* * * * *

[604]

* * *

[To postpone the report respecting the 22nd and 23rd --- 9; noes --- 1.] Ayes

* * * * *

To strike out the word "to" before establish justice --- 8; bites --- 2.] Ayes

[641]

MONDAY, SEPTEMBER 17, 1787.

JOURNAL

Monday September 17, 1787.

Detail of Ayes and Noes

	The Constitution Unanimously agreed to.	To deliver over the Journal and papers to the President.	
	[567]	[568]	[569]
New Hampshire	aye	aye	aye
Massachusetts	aye	aye	aye
Rhode Island	aye	aye	aye
Connecticut	aye	aye	aye
New York	aye	aye	aye
New Jersey	aye	aye	aye
Pennsylvania	aye	aye	aye
Delaware	aye	aye	aye
Maryland	aye	aye	no
Virginia	aye	aye	aye
North Carolina	aye	aye	aye
South Carolina	aye	dd	aye
Georgia	aye	aye	aye

MADISON

Monday Sepr. 17. 1787. In Convention

The engrossed Constitution being read, ...

Doct. Franklin rose with a speech in hand ....

* * * * *

[643]

... --- He then moved that the Constitution be signed ...

[644]

* * * * *

On the question to agree to the Constitution enrolled in order to be signed. It was agreed to by all the States answering ay.

* * * * *

[649]

MCHENRY

Monday Sepr. 1787.

Read the engrossed Constitution. Altered the representation in the house of representatives.

* * * * *

[651]

THE CONSTITUTION
OF THE UNITED STATES

We, the People of the United States, in Order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defense, promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish this Constitution for the United States of America.

ARTICLE I.

* * * * *

AMICUS CURIAE

BRIEF

(21) (19) (13) 14

No. 88-790; No. 88-805; Nos. 88-1125, 88-1309.

IN THE

Supreme Court of the United States

October Term, 1989

Supreme Court, U.S.
FILED
SEP 7 1989
JOSEPH F. SPANIOL, JR.
CLERK

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, et al.,

Appellants,

v.

RICHARD M. RAGSDALE, M.D., et al.,

Appellees.

ON APPEAL FROM THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

STATE OF OHIO,

Appellant,

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH, an Ohio Corporation, et al.,

Appellees.

ON APPEAL FROM THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

JANE HODGSON, M.D., et al.,

Appellants,

v.

STATE OF MINNESOTA, et al.,

Appellees.

ON APPEAL FROM THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF OF THE ANTI-DEFAMATION LEAGUE OF B'NAI B'RITH, B'NAI B'RITH WOMEN, CATHOLICS FOR A FREE CHOICE, AND WOMEN'S AMERICAN ORT AS *AMICI CURIAE* IN SUPPORT OF APPELLEES IN NOS. 88-790 AND 88-805 AND APPELLANTS IN NOS. 88-1125 AND 88-1309

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QUESTIONS PRESENTED

1. Do the Illinois, Minnesota and Ohio statutes at issue violate the establishment clause by endorsing one religious theory of when life begins?

2. Do the Illinois, Minnesota and Ohio statutes at issue impose an impermissible burden on a woman's free exercise of religion by restricting her fundamental religious interest in deciding whether to continue a pregnancy?

TABLE OF CONTENTS

	PAGE
QUESTIONS PRESENTED	i
TABLE OF AUTHORITIES	iii
INTEREST OF *AMICI CURIAE*	2
STATEMENT OF THE CASE	4
INTRODUCTION AND SUMMARY OF ARGUMENT	4
ARGUMENT	6
I. ABORTION IS AN ISSUE IMPLICATING DEEPLY HELD RELIGIOUS BELIEFS AND IS THE SUBJECT OF ONGOING RELIGIOUS DEBATE	6
II. THE STATUTES AT ISSUE VIOLATE THE ESTABLISHMENT CLAUSE	12
A. The Establishment Clause Requires Government Neutrality Concerning Religion	12
B. The Statutes At Issue Establish Religion	13
III. THE CHALLENGED STATUTES IMPOSE AN IMPERMISSIBLE BURDEN ON A WOMEN'S FREE EXERCISE OF RELIGION	18
A. For Many Women, the Decision Whether To Terminate a Pregnancy Is an Issue of Fundamental Religious Belief	19
B. Statutes Regulating Abortion Affect Fundamental Religious Interests And Are Subject To Strict Scrutiny	20
C. The Challenged Statutes Significantly Burden the Free Exercise of Religion	21
D. The Challenged Statutes Do Not Serve Any Compelling State Interests Which Would Justify Incursions in Religious Liberty	24
CONCLUSION	26

TABLE OF AUTHORITIES

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Aguillard v. Edwards, 107 S. Ct. 2573 (1987)	16
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Bowen v. Kendrick, 108 S. Ct. 2562 (1988)	3
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PAGE

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Skinner v. Oklahoma, 316 U.S. 535 (1942) 20
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No. 88-790; No. 88-805; Nos. 88-1125, 88-1309.

IN THE

Supreme Court of the United States

October Term, 1989

BERNARD J. TURNOCK, M.D., M.P.H., DIRECTOR OF THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH, ET AL.,

Appellants,

v.

RICHARD M. RAGSDALE, M.D., ET AL.,

Appellees.

ON APPEAL FROM THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

STATE OF OHIO,

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v.

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BRIEF OF THE ANTI-DEFAMATION LEAGUE OF B'NAI B'RITH, B'NAI B'RITH WOMEN, CATHOLICS FOR A FREE CHOICE, AND WOMEN'S AMERICAN ORT AS *AMICI CURIAE* IN SUPPORT OF APPELLEES IN NOS. 88-790 AND 88-805 AND APPELLANTS IN NOS. 88-1125 AND 88-1309

CONSENT OF THE PARTIES

All parties have consented to the filing of this brief and their letters of consent are being filed with the Clerk of the Court.

INTEREST OF AMICI CURIAE

This consolidated Brief *Amici Curiae* is submitted in support of appellees Richard M. Ragsdale and Akron Center for Reproductive Health, and appellant Jane Hodgson.

The Anti-Defamation League of B'nai B'rith ("ADL") is a national Jewish human relations organization dedicated to principles of religious and individual liberty including the right to privacy. ADL views abortion as an issue of personal and religious freedom. Accordingly, it believes that a woman's decision to have an abortion is constitutionally protected, with due regard for the right of women to exercise freely their own religious beliefs and not be constrained by the religious beliefs of others which have been given the sanction of state law. ADL recognizes that various religious faiths and denominations hold divergent views about abortion. In light of this multiplicity of views, ADL believes that no single religious group's beliefs should be legislatively established. Rather, individuals should be permitted broad latitude in deciding for themselves, in accordance with their own religious and moral convictions, whether to continue a pregnancy to term. Thus, ADL views most forms of government interference with an individual's exercise of religious conscience on the question of procreative choice, before viability, including those here at issue, to be unconstitutional under the First and Fourteenth Amendments. For these reasons, ADL supports the principles established in *Roe v. Wade*, 410 U.S. 113 (1973), and opposes erosion of the fundamental rights secured by that decision. ADL believes the Minnesota and Ohio parental notification requirements and Illinois' licensing scheme violate constitutionally protected principles of privacy, free exercise and establishment.

ADL has previously filed briefs in this Court in numerous cases dealing with First and Fourteenth Amendment principles, including *Allegheny County v. Greater Pittsburgh ACLU*, 109 S. Ct. 3086

(1989); *Webster v. Reproductive Health Services*, 109 S. Ct. 3040 (1989); *Bowen v. Kendrick*, 108 S. Ct. 2562 (1988); *Frazee v. Illinois Dep't of Employment Sec.*, 109 S. Ct. 1514 (1989); and *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986). Thus, the Anti-Defamation League is able to bring its special expertise relating to religious liberty and its experience advocating religious freedom to the issues raised on these appeals.

B'nai B'rith Women is an organization of 120,000 Jewish women who, since 1968, have advocated the right of women to choose for themselves on matters of reproduction. As members of a minority religion, BBW members are especially sensitive to keeping the state from restricting religious freedom, and as women BBW members have particular concerns about preserving their rights. Basic to the rights of every woman is that of deciding when and whether to have children, and so BBW firmly supports upholding these rights as outlined in *Roe v. Wade*.

Catholics for a Free Choice is an independent national membership organization established in 1974. One of CFFC's objectives is to protect the legal right of all women and girls to act as moral agents in decisions related to sexuality and reproductive health care without coercive legal or quasi-legal interference by religious institutions. As Catholics, CFFC members support policies of strict separation of church and state based not only on the U.S. Constitution but also on the Roman Catholic *Declaration on Religious Liberty* (Vatican II *Dignitatis Humanae* 7, December 1965) which declares:

> [T]he civil authority must see to it that the equality of the citizens before the law, which is itself society, is never violated either openly or covertly for religious reasons and that there is no discrimination among its citizens.

Women's American ORT has long held a pro-choice position on the issue of reproductive freedom, and believes that any erosion of the rights articulated in *Roe v. Wade* will be corrosive to fundamental individual liberties. Women's American ORT, and its 145,000 members, believe that when and whether to bear a child is a woman's private decision and opposes attempts to narrow the opportunity for women to control their own lives and be free from all levels of governmental intervention.

STATEMENT OF THE CASE

Amici adopt the Statement of the Case set forth by the appellees in *Turnock v. Ragsdale*, No. 88-790 and *State of Ohio v. Akron Center for Reproductive Health*, No. 88-805, and by appellants in *Hodgson v. State of Minnesota*, Nos. 88-1125 and 88-1309.

INTRODUCTION AND SUMMARY OF ARGUMENT

In *Roe v. Wade*, 410 U.S. 113 (1973), the Supreme Court held that the right of privacy, grounded in the concept of personal liberty guaranteed by the Constitution, encompasses a woman's right to decide whether to continue a pregnancy to term. The doctrine of *Roe v. Wade* "protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy." *Maher v. Roe*, 432 U.S. 464, 473-74 (1977). *Roe v. Wade* and its progeny effectuate the constitutional guarantee that in making critical, private decisions, a woman must be permitted to exercise her personal and religious conscience without state interference.

Webster v. Reproductive Health Services, 109 S. Ct. 3040 (1989), does not, by its terms, overrule *Roe v. Wade*. However, as Justice O'Connor expressly noted in her concurring opinion, and as the plurality indicated, while the Court deliberately chose not to overrule *Roe*, the various opinions are clearly an effort to reexamine its constitutional validity. *Webster*, 109 S. Ct. at 3060 (O'Connor, J., concurring). Moreover, by upholding the state statute challenged in *Webster*, this Court has dangerously narrowed the principles set forth in *Roe v. Wade*. Further, the various opinions have created uncertainty as to the appropriate standard of review.

Amici believe that the Court's decision in the three cases before it today will determine whether the constitutional guarantees recognized in *Roe v. Wade* will retain any vitality. As this Court has recognized, most recently in *Texas v. Johnson*, 109 S. Ct. 2533 (1989), the Constitution requires the Court to apply a strict scrutiny analysis to all cases impinging on First Amendment rights. Under this principle, the statutes at issue are unconstitutional under both the establishment and free exercise clauses.

These statutes place significant and direct burdens upon the exercise of the right to have an abortion and directly contravene the principles of *Roe v. Wade*. The Illinois statutory and regulatory scheme sets forth complex and oppressive regulations for the operation of private clinics in which abortions may be performed, and effectively regulates such clinics out of business. Parental notification statutes, such as the Minnesota and Ohio statutes, are designed to frustrate the decision to terminate a pregnancy and cause teenagers to delay abortions. This statutorily-imposed postponement of the abortion decision until a later, more dangerous time, and the concomitant creation of greater emotional turmoil and stress, impermissibly burden the right to choose whether to terminate or continue a pregnancy.

Although the protections in *Roe v. Wade* are grounded in the constitutionally-based right of privacy, the 7 to 2 majority in *Roe* recognized the religious nature of the abortion decision. *See Roe*, 410 U.S. at 150. More recently, Justice Stevens acknowledged the religious component in *Webster*, when he argued that the establishment clause of the First Amendment is also implicated by any state-imposed burden upon a woman's right to make, and implement, her own choice with respect to the termination of a pregnancy. 109 S. Ct. at 3081-82 (Stevens, J., concurring in part and dissenting in part). Any erosion of the principles articulated in *Roe v. Wade* damages not only the privacy interests at stake but also implicates religious freedoms.

Clearly, a woman's religious beliefs often play a major role in shaping her views about abortion. The religious component of the decision—and of the debate surrounding whether abortion should be allowed or not—is attested to by the fact that 67 religious organizations submitted their views as *amici curiae* in *Webster*. When a state creates significant obstacles to abortion, it effectively establishes one view on abortion, and unduly burdens the free exercise of religious conscience by those holding other views. The First Amendment does not permit such an establishment or tolerate such undue burdens absent a compelling state interest; in the conflict between dictates of law and dictates of conscience, freedom to pursue religious practice must prevail. As *Amici* will demonstrate below, freedom of religion is predicated on protecting matters of

individual conscience such as whether or not to terminate a pregnancy.

In Section I of this brief, *Amici* establish the religious nature of the abortion decision and demonstrate the multiplicity of religious views on abortion. Section II demonstrates that the Illinois, Ohio and Minnesota statutes promote a particular religious view, without advancing an articulable secular purpose, thus violating the establishment clause. Section III argues that these statutes also violate the free exercise clause because they cut deeply into fundamental religious rights, while failing to advance any of the interests they were purportedly designed to serve. For these and other reasons, these statutes are unconstitutional.[1]

ARGUMENT

I. ABORTION IS AN ISSUE IMPLICATING DEEPLY HELD RELIGIOUS BELIEFS AND IS THE SUBJECT OF ONGOING RELIGIOUS DEBATE

The decision to terminate a pregnancy is profoundly personal. An unwanted pregnancy affects every aspect of a woman's life, from her physical health and emotional well-being to her social relationships and economic standing. Moreover, the physical burdens imposed by pregnancy may also affect a woman's ability to provide emotional and financial care to her family. Accordingly, a woman's abortion decision must be guided by her unique personal circumstances, and not by the government. *See* S. Law, *Rethinking Sex and the Constitution*, 132 U. Pa. L. Rev. 955, 1017 (1984); Cates, *Legal Abortion: The Public Health Record*, 25 Science 1587, 1589 (1982).

For many women, religious beliefs pervade the decision whether to continue or terminate a pregnancy. When life begins is a theological question—a matter of belief and personal conviction. As this Court recognized in *Roe*,

[1]*Amici* are aware that both the parties and certain other *amici* briefs filed on the same side develop the privacy analysis at great length, and therefore *Amici* note their support for the position taken in those briefs. *Amici* submits this brief limited to a discussion of an issue about which it has special expertise and interest—the impact of the Court's decision in these three cases on freedom of religion.

> We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer.

410 U.S. at 159. No uniform theological view exists on the question of when human life begins or on the morality of abortion. Indeed, "the intensely divisive character of much of the national debate over the abortion issue reflects the deeply held religious convictions of many participants in the debate." *Webster*, 109 S. Ct. at 3085 (Stevens, J., concurring in part and dissenting in part). In the United States alone, there are over 200 religious groups and denominations, a majority of whom have a position on the morality of abortion. *See* C. Jacquet, ed., *Yearbook of American and Canadian Churches* (1984).

The Anti-Defamation League, B'nai B'rith Women and Women's American ORT, whose constituents represent different religious views on the issue of abortion, bring a personal interest and knowledge about Jewish positions on this issue to the debate. According to Jewish law, the fetus is not considered a human being and has no juridical personality until after its birth. For this reason, many Jews do not equate abortion with murder. Indeed, in certain circumstances, Jewish law views abortion not only as a permissible choice for a woman, but also as her religious and moral duty. *See* H. Donin, *To Be A Jew: A Guide to Jewish Observance in Contemporary Life* 140-141 (1972) ("[a]ll halakhic scholars agree that therapeutic abortions—namely, abortions performed in order to preserve the life of the mother— are not only permissible but mandatory."); D. Feldman, *Birth Control In Jewish Law: Marital Relations, Contraception And Abortion* 284 (1968) ("therapeutic abortion. . . is mandated by the Mishnah. . ."). [2]

Beyond this general consensus, however, different branches of Judaism, and different groups within each branch, disagree about the legal and moral status of abortion and about the specific circumstances under which it is permitted or required. Within the different

[2]The *Mishnah* is a compilation of oral Jewish law collected about A.D. 200 into a work known as the *Talmud*.

strands of Orthodox Judaism, for example, debate persists about the permissibility of therapeutic abortions in situations deleterious to the health of the mother, but not life-threatening, and in situations where there is a grave risk to her mental health. *Id.* at 284-294.

Most Orthodox Jewish groups have traditionally opposed abortion except in pressing situations, such as the endangerment of the mother's life. *Id.* at 275-283. Still other Orthodox Jews emphasize the physical and mental health of the woman as the paramount concern. "[T]he woman's pain 'comes first'. . . considered ahead of the husband's interest in his future child *and* ahead of the potential life of the child itself." *Id.* at 291 (emphasis in original). These groups believe that "insanity constitutes a danger to life and accordingly permit[ ] an abortion when it is feared that the mother may otherwise become mentally deranged." J.D. Bleich, *Contemporary Halakhic Problems* 363 (1977). Further, they counsel that an abnormal fetus may constitute "a grave necessity" in certain instances which would mandate an abortion (for example, if the possible abnormality of the fetus causes great mental anguish to the mother). *Id.* at 367. Finally, such Orthodox groups permit abortion when the pregnancy is the result of rape. D. Feldman, *supra*, at 287.

The Conservative, Reform and Reconstructionist branches of Judaism view abortion differently from many of their Orthodox counterparts and from each other. These branches sanction a woman's decision to terminate a pregnancy and endorse the holding of *Roe v. Wade*. Rabbi Balfour Brickner, Senior Rabbi of the Stephen Wise Free Synagogue and former director of the New York Federation of Reform Synagogues, notes that Reform Jewish thought is in accord with *Roe v. Wade*'s holding that: "The Constitution does not define 'person' in so many words. The use of the word is such that it has application only post-natally." *Hearings Before the Subcomm. on Civil and Constitutional Rights of the House Comm. on the Judiciary*, 94th Cong., 2nd Sess. 335 (March 24, 1976) (Rabbi Brickner, statement on behalf of the Religious Coalition for Abortion Rights) (citing *Roe v. Wade*, 410 U.S. at 157).

Similarly, the official Conservative Jewish position paper, recently issued, endorses the *Roe v. Wade* guarantees:

> Conservative Judaism continues to affirm its strong support for the 1973 Supreme Court decision of *Roe v. Wade*. Any weakening, limitation, or withdrawal of the *Roe v. Wade* decision is sure to produce tragic consequences. In light of the recent Supreme Court decision, we must be diligent in our efforts to safeguard and preserve the full personal and religious freedom given to the American people.

A Statement On Abortion (issued by the Social Justice Committee of the Rabbinical Assembly) (July, 1989).

Even among these Jewish groups, however, there is disagreement on the rationale for upholding a woman's right to terminate a pregnancy. Under certain circumstances, such as when a pregnancy threatens a woman's life, as the Orthodox view counsels, or where necessary to preserve a woman's health, Jewish law may compel termination of a pregnancy. *See McRae v. Califano*, 491 F. Supp. 630, 696 (E.D.N.Y.), *rev'd sub nom. Harris v. McRae*, 448 U.S. 297 (1980) (citing testimony of Rabbi David Feldman). Others would protect a woman's right to choose an abortion as the exercise of her own religious and moral convictions. See M.D. Bial, *Liberal Judaism At Home; The Practices Of Modern Reform Judaism* 13 (1971).

Many Reform Jews base their support of a woman's right to have an abortion before a fetus is viable on the belief that a woman should have control over her body. *Id.* at 13. Others stress a woman's physical, psychological and emotional well-being in support of her right to choose an abortion. *Id.* at 12-13. Finally, some view abortion as necessary to safeguard the right of a couple to produce only that number of children for whom they can properly provide. *See* Statement of Rabbi Brickner, *supra*, at 337.

Like the Jewish community, Christians have diverse and often sharply opposing views on abortion. Thus, for example, among the Baptist churches, there is no distinct moral or theological view on the subject of abortion. Denominational pronouncements reflect the views and guidance of elected representatives, but are not considered binding positions. Some authorities within the Baptist Church support liberty of conscience and the exercise of individual moral judgment, and advocate a public policy which guarantees the right of each woman to make her own decision with respect to abortion.

See McRae v. Califano, 491 F. Supp. at 697 (citing statement of Dr. James E. Wood, Executive Director of the Baptist Joint Committee on Public Affairs). However, the Southern Baptist Convention opposes "abortion on demand," and advocates legislative restrictions on abortion. *Id.* at 699 (citing 1976 and 1977 Resolutions of the Southern Baptist Convention).

The Episcopal Church, USA has consistently supported a woman's right to choose abortion and maintain control over her body. At its 1988 General Convention, the Church declared support for the " 'termination of pregancy' particularly in those cases where 'the physical and mental health of the mother is threatened seriously, or where there is substantial reason to believe that one child would be badly deformed in mind or body, or where the pregnancy has resulted from rape or incest'. . . . Termination of pregnancy for these reasons is permissible." Letter from Ann Smith, Office of the Presiding Bishop and the Executive Council of the General Convention, the Episcopal Church Center (March 6, 1989).

The General Synod of the United Church of Christ supports the legality of abortion, in recognition that "life is less than perfect and the choices that people have to make are difficult." United Church of Christ, *Abortion: A Resolution Of The 12th General Synod Of The United Church Of Christ* (Public Policy Pamphlet 12GS-12) (1979). The United Church of Christ thus sanctions a woman's right to consider abortion as an expression of her personal conscience, stressing only that she "act faithfully" when making such a decision. *Id.* In 1971, the Church sanctioned the weighing of such considerations as the "welfare of the whole family, its economic condition, the age of the parents, their view of the optimum number of children consonant with their resources and the pressures of population" when deciding whether to bear a child. *Freedom Of Choice Concerning Abortion* (adopted by the General Synod of the United Church of Christ) (June, 1971).

Other religious denominations respect a woman's right to choose precisely because of the diversity of views held by their members. For example, in its policy statement, the Presbyterian Church noted that it "exists within a very pluralistic environment. [The Church's] own members hold a variety of views. It is exactly that plurality of beliefs that leads us to the conviction that the decision regarding

abortion must remain with the individual, to be made on the basis of conscience and personal religious principle free from governmental interference." *Covenant And Creation: Theological Reflections On Contraception And Abortion* at 51 (adopted by the 195th General Assembly of the Presbyterian Church) (1983).

Canonical and theological history establishes that no unanimous tradition on the question exists within the Catholic Church. *See* Maguire, *The Catholic Legacy And Abortion*, 114 Commonweal 657 (1981). Furthermore, as *Amicus* Catholics for a Free Choice poignantly demonstrate, committed Catholics do not all agree on the subject of abortion. *See also* Brief *Amicus Curiae* of Catholics For A Free Choice, *Webster v. Reproductive Health Services*. Many Catholics view the abortion decision as one which must be evaluated by the individual with reference to theology, church tradition and individual prayer. *Id.* at 27.

The current official doctrine of the Roman Catholic Church sharply conflicts with that of many Jewish groups and Protestant denominations. *The Declaration on Abortion of the Sacred Congregation for the Doctrine of the Faith of November 18, 1974*, the current text on the teachings of the Roman Catholic Church, states that life begins at fertilization, and that abortion is immoral, although it does not take a position on the commencement of moral or legal personhood.

By passing legislation which restricts the rights of women to choose whether to continue their pregnancies, Illinois, Minnesota and Ohio have intruded into an area where the First Amendment's protection of religious freedom requires that women be allowed to follow the dictates of their individual consciences. These states have made it impossible for women to decide, in keeping with their sincere religious beliefs about when life begins and when termination of a pregnancy is appropriate, whether to have an abortion or continue a pregnancy. Abortion must remain a legal option for women so that they are free to consult their own conscience and beliefs in making a choice.

The establishment clause and the free exercise clause of the First Amendment require government neutrality and reasonable accommodation in the face of competing religious claims. These constitu-

tional principles simply do not allow states to set conditions for the termination of a pregnancy which effectively burden a woman's freedom of choice in such a way as to require her to follow the religious doctrine of a particular sect or sects and conform her conduct accordingly, even though she holds no such religious beliefs. "In the relationship between man and religion, the State is firmly committed to a position of neutrality." *School Dist. of Abington Township v. Schempp*, 374 U.S. 203, 226 (1963).

II. THE STATUTES AT ISSUE VIOLATE THE ESTABLISHMENT CLAUSE

A. The Establishment Clause Requires Government Neutrality Concerning Religion

The First Amendment's establishment clause "requires the state to be a neutral in its relations with groups of religious believers and non-believers." *Everson v. Board of Educ.*, 330 U.S. 1, 18 (1947). Last term, this Court reaffirmed that "government may not promote or affiliate itself with any religious doctrine or organization." *Allegheny County v. Greater Pittsburgh ACLU*, 109 S. Ct. 3086, 3099 (1989).

The Court has established a three-prong test to determine whether a statute violates the establishment clause. "First, the statute must have a secular legislative purpose; second, its principal or primary effect must be one that neither advances nor inhibits religion; finally the statute must not foster 'an excessive government entanglement with religion.'" *Lemon v. Kurtzman*, 403 U.S. 602, 612-13 (1971) (citation omitted).

The *Lemon* test was further refined in *Allegheny*, 109 S. Ct. at 3101, where the Court described the establishment clause protection as follows:

> Whether the key word is "endorsement," "favoritism," or "promotion," the essential principle remains the same. The Establishment Clause, at the very least, prohibits government from appearing to take a position on questions of religious belief or from "making adherence to a religion relevant in any way to a person's standing in the political community." *Lynch v. Donnelly*, 465 U.S. at 687 (O'Connor, J., concurring).

A law will not pass constitutional muster if the purported secular purpose is a "sham". *Wallace v. Jaffree*, 472 U.S. 38, 74-75 (1985) (O'Connor, J., concurring). Thus, the "mere existence of some secular purpose" is not enough. *Lynch v. Donnelly*, 465 U.S. 668, 691 (1984) (O'Connor, J., concurring). The stated purpose must be "sincere." *Wallace v. Jaffree*, 472 U.S. at 75 (O'Connor, J., concurring).

As *Amici* argue below, while the purported purpose behind legislation restricting a woman's choice whether to continue her pregancy to term may be secular (*e.g.*, family harmony, protection of a woman's health), closer inspection reveals that these statutes are in fact animated by the religious beliefs of the legislators as to when life begins and when abortions should be permissible under their theological scheme. Although the majority in *Webster* did not address this First Amendment component of the attack on the Missouri statute, Justice Stevens faced this issue directly, concluding that the Missouri statute was an unconstitutional endorsement of one religious theory of when life begins. *Webster*, 109 S. Ct. at 3082 (Stevens, J., concurring in part and dissenting in part).

As this Court continues to review statutes which restrict women's right to choose whether to carry a pregnancy to term, the concerns raised by Justice Stevens in *Webster* arise with renewed urgency. Indeed, if the Illinois, Minnesota and Ohio statutes are permitted to stand, especially when coupled with *Webster*, the cumulative effect would be a serious erosion of establishment clause principles. As Justice Blackmun emphasized, writing for the Court in *Allegheny*, "we have expressly required 'strict scrutiny' of practices suggesting 'a denominational preference'. . . in keeping with 'the unwavering vigilance that the Constitution requires' against any violation of the Establishment Clause." 109 S. Ct. at 3109 (citations omitted).

B. The Statutes At Issue Establish Religion

The Illinois, Ohio and Minnesota statutes violate the establishment clause in several ways. First, they fail to serve or further the purportedly secular purposes identified by the states. Rather, they promote the religious view that life begins at conception, and are a thinly-veiled attempt to block access to abortion. "That fact alone compels a conclusion that the statute[s] violate[ ] the Establishment

Clause." *Webster*, 109 S. Ct. at 3082-83 (Stevens, J., concurring in part and dissenting in part), citing *Wallace v. Jaffree*, 472 U.S. at 56.

Illinois has argued that its rigid regulation of outpatient abortion clinics has a medical purpose—the protection of women's health. *Ragsdale v. Turnock*, 625 F. Supp. 1212, 1230 (N.D. Ill. 1985), *modified*, 841 F.2d 1358 (7th Cir. 1988). The record is to the contrary: Illinois was unable to present any evidence that the particular regulations at issue here were enacted to further that purported purpose. *Ragsdale*, 625 F. Supp. at 1230. In fact, the legislative history demonstrates the legislators' concern with the status of the fetus—a religious concept—and not the health of the woman or the safety of the clinics. The Illinois General Assembly intended to obstruct women's access to abortions when it created the challenged statutory scheme in 1973. *See Ragsdale*, P. Jt. App. at A4-A5[3] ("We must make the best of a very sorry situation by at least regulating that procedure so that the Abortion Mills will not proliferate") (statement of Rep. Hyde). This underlying impermissible purpose has been very successfully served by the Illinois statute—many private clinics have had to close since the statute went into effect, and there are vast areas of the state where there are no facilities available to women seeking to terminate a pregnancy. *Ragsdale*, 625 F. Supp. at 1227.

After reviewing the legislative history, the Illinois district court found that the regulatory scheme did not advance the purported secular legislative purpose. *Id.* (defendants failed to produce "any evidence at all" that the "statutes and regulations are medically necessary"). Indeed, the Seventh Circuit found that the Illinois legislature made the regulations at issue applicable to all clinics rather than clinics that perform abortions alone in "an effort to save the statute from unconstitutionality." *Ragsdale*, 841 F.2d at 1369.

The lack of any plausible secular explanation for the intrusive regulatory scheme and the legislators' focus on the nature of the fetus and not on the well-being and health of the woman involved demonstrates that the Illinois statute was intended to endorse the

[3]The proceedings of the Illinois House of Representatives General Assembly are included in plaintiffs' joint appendix.

sectarian position that life begins at conception. The establishment clause does not allow government to mandate one religious view. *See Allegheny*, 109 S. Ct. at 3104-05.

Minnesota's and Ohio's parental notification statutes similarly impose one religious view about abortion on their citizens. Both Minnesota and Ohio have argued, like Illinois, that the statutes have a valid secular purpose—the protection of the well-being of minors by encouraging them to discuss the abortion decision with their parents. *Hodgson v. State of Minnesota*, 648 F. Supp. 756, 766 (D. Minn. 1986), *rev'd*, 853 F.2d 1452 (8th Cir. 1988). *Akron Center for Reproductive Health v. Rosen*, 633 F. Supp. 1123 (N.D. Ohio 1986), *aff'd sub nom. Akron Center for Reproductive Health v. Slaby*, 854 F.2d 852 (6th Cir. 1988). A careful analysis of the legislative history, however, leads to the inescapable conclusion that the states were actually motivated by a non-secular purpose—preventing minors from having abortions in order to further the legislators' beliefs about when life begins. *Hodgson; Akron*.

The Minnesota legislators made little attempt to disguise the fact that they were motivated by their belief that life begins at the moment of conception and abortions should be strongly discouraged if not outlawed. *Hodgson*. Influential supporters of the legislation said they hoped, by encouraging minors to continue their pregnancies, to "save lives." *Id.* The Minnesota trial court found that the Minnesota legislature was motivated by "a desire to deter and dissuade minors from choosing to terminate their pregnancies." *Id.* Significantly, although the Eighth Circuit reversed the legal conclusions of the district court with regard to the constitutionality of the parental notice provision, the appellate court did not contradict the factual finding that the legislators were motivated by improper religiously-based purposes.

Both the district court and the Sixth Circuit apparently accepted, at face value, Ohio's assertion that the statute's purpose was to facilitate parental involvement in child rearing. *See Akron Center for Reproductive Health v. Rosen*, 633 F. Supp. at 1130-1131, *aff'd*, 854 F.2d at 863. However, as the above discussion of *Hodgson* and *Ragsdale* indicates, it is probable that at least some of the legislators were seeking to advance their religious view of when life begins, an impermissible government purpose. Both the district and appellate

courts *did* conclude that Ohio could not present any legitimate state interest behind its onerous bypass procedures, *Akron v. Rosen*, 633 F. Supp at 1137; *Akron v. Slaby*, 854 F.2d at 863, presumably because the only reason for such a cumbersome process was to make it more difficult for minors to terminate their pregnancies.

Because the Illinois, Minnesota and Ohio statutes do not advance the interests they purportedly were designed to serve, the only plausible reason for such legislation is to further the belief that life begins at conception. Of course, this non-secular belief, unsupported by medical knowledge, may not be established by state law. *See Webster*, 109 S. Ct. at 3082 (Stevens, J., concurring in part and dissenting in part). *See also Aguillard v. Edwards*, 107 S. Ct. 2573, 2582 (1987) ("The Legislative history documents that the [creation science] Act's primary purpose was to change the science curriculum of public schools in order to provide persuasive advantage to a particular religious doctrine . . . ."); *Wallace v. Jaffree*, 472 U.S. at 57-61.

The challenged statutes also fail under the 'effect' prong of the *Lemon* test. The Illinois regulatory scheme, which imposes onerous regulations unrelated to health concerns, *Ragsdale*, 625 F. Supp. at 1230, has a perceived and actual effect of advancing the non-secular aims of certain religions. The regulations essentially endorse the religious belief that life begins at conception, to the detriment of those who do not share it. *See Roemer v. Board of Public Works*, 426 U.S. 736, 747 (1976) ("[t]he State must confine itself to secular objectives, and neither advance nor impede religious activity").

The Ohio and Minnesota statutes fail under the second prong of the *Lemon* test as well. While Minnesota had asserted that its parental notice statute sought to encourage intra-family communication, no witnesses involved in the statute's implementation testified that the statute had a beneficial effect on the minors whom it was presumably intended to assist. *Hodgson*, 648 F. Supp. at 775. What the requirements of parental notification or judicial permission have done is to tell teenage girls that the state endorses the religious view that abortions are wrong. The placement of burdensome barriers, *see, e.g., Akron v. Rosen*, 633 F. Supp. at 1137; *Hodgson*, 648 F. Supp. at 764, in the way of young women seeking abortions conveys

the unmistakable message that abortion must be discouraged. This "symbolic union of church and state" cannot be allowed to stand. *Grand Rapids Sch. Dist. v. Ball*, 473 U.S. 373, 390 (1985); *Larkin v. Grendel's Den, Inc.*, 459 U.S. 116, 126-127 (1982).

In each case, the statute's message that abortion is wrong promotes "one religion or religious theory against another or even against the militant opposite" in contravention of the First Amendment. *Epperson v. Arkansas*, 393 U.S. 97, 104 (1968). A woman from either Minnesota, Ohio or Illinois whose sincere religious beliefs have led her to decide to terminate a pregnancy has been ostracized by her state government and given an unmistakable message—not only does the state believe abortions are morally reprehensible, but also that the State will prevent her from acting on her religious beliefs. As this Court held last term in *Allegheny*, such favoritism is unconstitutional. 109 S. Ct. at 3101.

The three state statutes also violate the entanglement prong of the *Lemon* test, and will lead to the kind of religious and political divisiveness condemned by this Court in *Engel v. Vitale*, 370 U.S. 421, 436 (1962). State enforcement of restrictions on abortions, whether relating to the availablity of clinics (Illinois) or the requirement of parental notice (Minnesota and Ohio), put state governments in the position of aiding those religions and religious groups which believe abortion is wrong, to the detriment of those who believe decisions about terminating a pregnancy should be left to individual choice. As the weeks since this Court issued its *Webster* opinion have demonstrated, the tension between these two approaches has become a major political issue at the state and local level. There will be no end to the political controversy, and to the involvement of various religious groups in that controversy, unless this Court properly places a barrier between government and the individual choice to decide whether to continue a pregnancy.

Permitting the state to communicate the religious message that abortion is morally reprehensible flouts the guarantees of the establishment clause. The First Amendment prohibits the fusion of government and religion which occurs whenever government endorses or supports the theological tenets of one religion or several, over others. *See Grand Rapids Sch. Dist. v. Ball*, 473 U.S. at 389 (when

the government "conveys a message of governmental endorsement or approval of religion, a core purpose of the establishment clause is violated"). *See also Everson*. As this Court has said:

> The wholesome "neutrality" of which this Court's cases speak thus stems from a recognition of the teachings of history that powerful sects or groups might bring about a fusion of government and religious functions or a concert of dependency of one upon the other to the end that official support of the state or federal government would be behind the tenets of one or of all orthodoxies; this is what the Establishment Clause prohibits.

School Dist. of Abington v. Schempp, 374 U.S. 203 at 222. *See also Allegheny*, 109 S. Ct. at 3099-3105.

The Illinois, Minnesota and Ohio statutes have placed government "behind the tenets" of some religions, to the detriment of *Amici* and other religious groups. This imposition violates the very core of the establishment clause.

III. THE CHALLENGED STATUTES IMPOSE AN IMPERMISSIBLE BURDEN ON A WOMAN'S FREE EXERCISE OF RELIGION

The three statutes before this Court purport to address a variety of state interests, including the mother's health, potential human life, and intra-family communication. As discussed above, these purported purposes merely provide a legislative cover for the real objective of the statutes, which is to impose such burdens on women seeking to terminate pregnancies that they are deterred from doing so. However, it is well established that states may not vindicate even legitimate interests in a manner which unduly infringes upon individuals' free exercise rights. *See School Dist. of Abington v. Schempp*, 374 U.S. at 222. The free exercise clause was designed to prohibit governmental interference with the individual's right to act in accordance with the dictates of her own conscience in matters of religion. *Wallace v. Jaffree*, 472 U.S. at 52. *See also United States v. Ballard*, 322 U.S. 78, 87 (1944).

Nowhere is this principle of government neutrality more important than in the highly controversial and emotional issue of reproductive rights. *See Griswold v. Connecticut*, 381 U.S. 479 (1965); *See*

also Eisenstadt v. Baird, 405 U.S. 438 (1972); S. Law, *supra* at 1023. Because, for many women, the abortion decision necessarily implicates a woman's religious beliefs, restrictions on a woman's decision may interfere with the exercise of religious conscience by imposing one view (opposing abortion) and by stifling individual choice.

A. For Many Women, the Decision Whether To Terminate a Pregnancy Is an Issue of Fundamental Religious Belief

In *Roe v. Wade*, the Court held that a woman's right to decide whether to terminate her pregnancy was "fundamental." 410 U.S. 113, 152. *See also Carey v. Population Services Int'l*, 431 U.S. 678, 685 (1977) ("[t]he decision whether or not to beget or bear a child is at the very heart of [the] cluster of constitutionally protected choices"). Since *Roe v. Wade* was decided, the Court "repeatedly and consistently has accepted and applied the basic principle that a woman has a fundamental right to make the highly personal choice whether or not to terminate her pregnancy." *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 420 n.1 (1983). Moreover, as this Court has noted, "[t]he States are not free, under the guise of protecting maternal health or potential life, to intimidate women into continuing pregnancies." *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 759 (1986).

The plurality opinion in *Webster* tries to beg the question by claiming that "there is wisdom in not unnecessarily attempting to elaborate the abstract differences between a 'fundamental right' to abortion . . . a 'limited fundamental constitutional right'. . . or a liberty interest protected by the Due Process Clause . . . ." *Webster*, 109 S. Ct. at 3058. However, as the *Webster* dissent correctly points out, the Court's failure to renew its commitment to protecting the fundamental privacy and First Amendment interests at stake has already led to an increasingly hostile and divisive political debate. 109 S. Ct. at 3079 (Blackmun, J., concurring in part and dissenting in part).

Amici urge the Court, in the three cases before it today, to reaffirm a half century of decisions holding that the right to make an individual decision regarding childbearing free from government

coercion—and to the exercise of one's religious beliefs and conscience free from governmental endorsement or disapproval—is a fundamental right. *See Wallace v. Jaffree; Roe v. Wade; Eisenstadt v. Baird*; *Griswold v. Connecticut; Skinner v. Oklahoma*, 316 U.S. 535 (1942).

Amici believe that this fundamental right is grounded in both privacy rights and freedom of religious conscience. State statutes regulating abortion restrict a woman's ability to exercise freely her private religious beliefs. Requiring a woman to conform her actions to the government's view of when life begins is repugnant to the protections of the free exercise clause.

This Court must not allow Illinois, Ohio and Minnesota to prevent women from exercising their religious freedom.

B. Statutes Regulating Abortion Affect Fundamental Religious Interests and Are Subject to Strict Scrutiny

As this Court has repeatedly acknowledged, the government may not burden the free exercise of religion unless it can establish that "an inroad on religious liberty. . . is the least restrictive means of achieving some compelling state interest." *Thomas v. Review Bd. of the Indiana Employment Sec. Div.*, 450 U.S. 707, 718 (1981). *See also Hobbie v. Unemployment Appeals Comm'n of Florida*, 480 U.S. 136 (1987). The Court has further emphasized that "only those interests of the highest order and those not otherwise served can overbalance legitimate claims to the free exercise of religion." *Wisconsin v. Yoder*, 406 U.S. 205, 215 (1972); *Sherbert v. Verner*, 374 U.S. 398, 406 (1963) (when evaluating free exercise claims, the Court must consider "whether some compelling state interest . . . justifies the substantial infringement of [a] First Amendment right").

This First Amendment standard of review is applicable whether unemployment benefits are at stake, *see Hobbie*, or schooling for children, *see Yoder*, or the right to decide whether to continue a pregnancy, as in *Roe v. Wade*. The plurality decision in *Webster* failed to address the First Amendment component to the rights implicated by the Missouri abortion statute. For this reason, the plurality's suggestion that restrictions on abortion may be evaluated

under a lesser standard of review is unpersuasive. Indeed, the Court itself recently reiterated that statutes which implicate First Amendment rights must be strictly scrutinized. *Texas v. Johnson*, 109 S. Ct. 2533 (1989) (applying the strict scrutiny test to strike down a state court conviction for desecration of the American flag).

Justice O'Connor's effort in *Webster* to respond to the uncertainties of the plurality opinion nevertheless failed to address the First Amendment aspect of the abortion debate. *Webster*, 109 S. Ct. at 3058-64 (O'Connor, J., concurring). It is this constitutional dimension—which only Justice Stevens addressed in his partial concurrence and partial dissent — that requires this Court to apply the very highest standard of review to any statute, including those regulating abortion, which restrict the enjoyment of rights guaranteed by the First Amendment.

Under this standard, as properly applied, only a compelling state interest justifies state infringement on fundamental free exercise rights. *See, e.g., Hobbie*, 480 U.S. at 141-42; *Thomas*, 450 U.S. at 718; *Sherbert*, 374 U.S. at 406. In keeping with these cases and consistent with this Court's logic, the statutes at issue must be evaluated under a strict scrutiny standard. *See Thomas*, 450 U.S. at 718; *City of Akron*, 462 U.S. at 427.

As demonstrated below, the instant statutes profoundly burden women's rights to the free exercise of their religious choices about childbearing. Moreover, Illinois, Minnesota and Ohio have failed to demonstrate that the statutes further a compelling state interest.

C. The Challenged Statutes Significantly Burden the Free Exercise of Religion

Illinois, Minnesota and Ohio have burdened women's free exercise rights by making it impossible for them to carry out their religious beliefs regarding a uniquely personal and moral decision. Although a woman in any of these states is still able to decide, on the basis of her personal religious beliefs or convictions, that she wishes to terminate her pregnancy, she may be prevented from implementing her decision. This Court has repeatedly held that state regulations which prevent someone from exercising his or her reli-

gious beliefs, without a compelling state interest, are unconstitutional. *See, e.g., Hobbie; Yoder*.

The Illinois licensing scheme virtually regulates private facilities out of existence, thus making it extremely difficult, if not impossible, for a woman in that state to obtain an abortion. As the district court judge found, "the challenged statutes and regulations do place a very real and a very heavy burden on the right of a woman to decide to terminate her pregnancy. The effect of the statutory and regulatory scheme is to increase the cost of abortions and decrease their availability." *Ragsdale*, 625 F. Supp. at 1227. Thus, the clear effect of the Illinois statute is to block the ability of Illinois women to obtain abortions. *Id.* at 1227 ("as a result of the scheme . . . the only outpatient abortion facility in northwest Illinois, will close . . . .").[4]

The Minnesota and Ohio statutes also place serious barriers in the way of a woman's access to abortion, requiring a young woman to endure a sometimes insurmountable obstacle course of regulations before she can obtain an abortion.[5] The Ohio statute requires the attending physician personally to notify the parent, which impinges upon the minor's right to privacy, leads to intra-family conflict, and requires violation of the physician/patient privilege. It is also directly in conflict with the holding in *City of Akron*, 462 U.S. at 448, that states may not require physicians personally to obtain informed consent from parents of a minor.

Further, although there is a judicial bypass procedure, its burdensome pleading requirements and standard of proof vitiate any protection the legislature intended to accord young women. This Court has held that a bypass proceeding must assure "anonymity and sufficient expedition to provide an effective opportunity for an abortion to be obtained . . . ." *Bellotti v. Baird*, 443 U.S. 622, 644

[4]Moreover, since *Webster* appears to allow states to forbid the use of public facilities for abortions, upholding the restrictions on private facilities in the Illinois statute would mean that a state could virtually legislate abortion facilities out of existence.

[5]Amici refer to appellees' briefs in *Ragsdale* and *Akron Center for Reproductive Health* and appellant's brief in *Hodgson* for a fuller explanation of the burdens imposed by the statutes.

(1979). The potential three week wait for a judicial decision in Ohio does not comply with any notion of expediency. By requiring a woman to disclose her name and address, the Ohio statute fails to guarantee a woman's anonymity.

The Minnesota statute provides that a minor seeking an abortion must notify both of her parents and may not thereafter have an abortion for forty-eight hours. This mandatory two parent notification, which does not take into account whether the minor is living with both of her parents (or one or neither), amounts to an "absolute, and possibly arbitrary, veto" deemed unconstitutional in *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 74 (1976). As with the Ohio statute, Minnesota's legislation will only promote family strife and subject the minor to additional emotional distress during an already difficult time. *Hodgson*, 648 F. Supp. at 763-64. Minnesota, like Ohio, has a judicial bypass provision which, because of its cumbersome procedures and built-in delays, is also unduly burdensome. *Hodgson*, 648 F. Supp. at 776.

The fact that these two statutes are directed at minors, in whose protection states may have a heightened interest, does not eliminate the constitutional concerns. "Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights." *Danforth*, 428 U.S. at 74. Indeed, this Court has recognized minors' First Amendment rights in a number of contexts. *See, e.g., Tinker v. Des Moines Indep. Comm. Sch. Dist.* 393 U.S. 503, 506 (1969); *Hazelwood Sch. Dist. v. Kuhlmeier*, 108 S. Ct. 562 (1988).

Like adult women, many teenage girls have sincere religious beliefs which are protected by the free exercise clause. They face the same difficult choices as mature women in deciding whether to continue a pregnancy and should not have to overcome greater obstacles in effectuating that decision. Any contrary conclusion ignores this Court's recent decision in *Stanford v. Kentucky*, 109 S. Ct. 2969 (1989). There, the Court held that minors and adults are equally responsible for their criminal activity and that minors, like adults, can be put to death for murder. The majority held that minors are "mature enough to understand that murdering another human

being is profoundly wrong, and to conform [their] conduct to that most minimal of all civilized standards." *Id.* at 2977. *Amici* do not necessarily endorse the Court's view that the Constitution allows the government to put minors to death. However, if minors can be presumed mature enough to appreciate the consequences of their actions and to be sentenced to death, it surely follows that they are mature enough to make and carry out decisions about procreation.

D. The Challenged Statutes Do Not Serve Any Compelling State Interests Which Would Justify Incursions in Religious Liberty

Any purportedly permissible state interest claimed by Illinois, Ohio and Minnesota in support of their legislation dissipates upon careful analysis. The purported state interest underlying the Illinois law is the preservation and protection of a patient's health. However, the Seventh Circuit found that: (1) "many of the physical plant requirements . . . have 'no medical justification whatsoever' when applied to first and early second trimester abortions"; and (2) the certificate of need proceeding requirement does not serve any articulable interest. *Ragsdale*, 841 F.2d at 1373-74. The record before this Court in these cases and many others establishes, without contradiction, that the health effects of unwanted pregnancies and delays in securing abortions are devastating. *See* National Research Council, *Risking the Future: Adolescent Sexuality, Pregnancies, and Childbearing* (1987).

The state interest underlying the Minnesota and Ohio statutes is purported to be the fostering of intra-family communication and protection of the well-being of pregnant minors. However, neither of these statutes effectuates the state's interest in maternal health; nor does either further intra-family communication. Indeed, intra-family communication, if poor, is unlikely to be improved by legislatively-mandated communication. Far from protecting minors, the notice/bypass statutes force minors into situations that can only increase their fear and anxiety, causing them to postpone the abortion until a later, more dangerous time. The statutes may also coerce a young woman into continuing a pregnancy against her personal wishes, religious beliefs and best interests, an equally unacceptable alternative.

The district court in *Hodgson* found that the Minnesota statute "fails to serve the State's asserted interest in fostering intra-family communication and protecting pregnant minors." 648 F. Supp. at 775. Similarly, the Ohio district court found that the Ohio statute overstresses parental interests and thus "misperceives" the permissible interest a notification statute may serve—the protection of minors. *Akron v. Rosen*, 633 F. Supp. at 1137. The Ohio district court found no compelling state interest to justify the burdensome notice/bypass scheme there. *Id.* Moreover, the Sixth Circuit concluded that "the State of Ohio has presented no legitimate justification for imposing its pleading requirement which . . . is a 'procedural trap.'" *Akron v. Slaby* at 862-63. As the lower courts have already determined, these statutes are not even rationally related to the advancement of the purported state interests.

The challenged statutes have been animated by the religious view that abortion is morally wrong and that life begins at conception. They impose that view on women who, as a matter of religious conscience, believe differently. Because these statutes conflict with the rights guaranteed by the First Amendment, they must fall.

Amici concur with the views of an Episcopal priest, who recently said:

> Whether pro-choice or anti-abortion, you do not have the right in this diverse, pluralistic society to force beliefs and opinions on others. There can never be a just law requiring uniformity of behavior on the abortion issue.[6]

Indeed, the First Amendment stands as a bulwark against government-enforced uniformity in exercising and implementing religious convictions.

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[6] *A Priest on Abortion: Women as the Proper Moral Agent*, Los Angeles Times, August 6, 1989, Part V, at 1, col. 1.

CONCLUSION

For the foregoing reasons, the decisions of the Courts of Appeal for the Sixth and Seventh Circuits should be affirmed and the decision of the Court of Appeals for the Eighth Circuit should be reversed.

Respectfully submitted,

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AMICUS CURIAE

BRIEF

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IN THE

Supreme Court of the United States

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BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, *et al.*,

Appellants,

—v.—

RICHARD M. RAGSDALE, M.D., *et al.*,

Appellees.

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FOR THE SEVENTH CIRCUIT

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TABLE OF CONTENTS

PAGE

TABLE OF AUTHORITIES iii

CONSENT OF PARTIES 1

INTEREST OF *AMICI* 2

SUMMARY OF ARGUMENT 4

ARGUMENT 8

I. FOLLOWING THE RECOGNITION BY THIS COURT OF A WOMAN'S RIGHT TO TERMINATE A PREGNANCY, STATE LEGISLATURES HAVE PARTICIPATED WITH COURTS IN THE TRADITIONAL PROCESS OF PROBING THE BOUNDARIES OF THAT RIGHT, SUBJECT TO FINAL DEFINITION BY THIS COURT 8

A. Throughout Our History, Courts and Legislatures Have Shaped the Development of Constitutional Law by Performing Their Respective Constitutional Functions 8

B. *Roe* v. *Wade* Provided the States and the Courts with Workable Standards for the Regulation of Abortion 14

1. The *Roe* standards, premised on "viability," emerged in an active case and controversy that required this Court to balance state interests and the fundamental rights of women 14

PAGE

2. A constitutional standard based on viability emerged as the most appropriate way to balance the fundamental right to procreative choice and the states' legitimate interests in protecting potential life and the health of pregnant women..... 15

3. The viability standard has proven workable for the states and the courts 19

II. THE BOUNDARIES OF THE CONSTITUTIONAL RIGHT TO DECIDE WHETHER TO BEAR A CHILD DO NOT ENCOMPASS EITHER THE ABORTION-SPECIFIC PARTS OF THE ILLINOIS REGULATIONS OR THE APPLICATION OF THE GENERAL REGULATIONS TO ABORTION CLINICS, SO THAT THE INJUNCTION BELOW IS PROPER ANT SHOULD BE AFFIRMED ... 22

A. The Illinois Provisions on Their Face Unconstitutionally and Directly Burden the Fundamental Right of Choice, and Are Justified by No Countervailing State Interest.. 23

B. The Illinois ASTC Requirements Cannot Be Justified As Applied to Abortion Clinics... 26

CONCLUSION 28

TABLE OF AUTHORITIES

Cases: PAGE

Aguilar v. *Felton*, 473 U.S. 402 (1985) 10n

Akron v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983) 18, 18n, 20n

Aptheker v. *Secretary of State*, 378 U.S. 500 (1964).... 27

Baldwin v. *G. A. F. Seelig, Inc.*, 294 U.S. 511 (1935).. 14n

Bellotti v. *Baird*, 443 U.S. 622 (1979) 20n

Bender v. *Williamsport Area School District*, 475 U.S. 534 (1986) 11n

Brown v. *Board of Education*, 347 U.S. 483 (1954) ...9n, 10, 12, 13, 21

Buckley v. *Valeo*, 424 U.S. 1 (1976)..... 12n

Central Hudson Gas & Electric Corp. v. *Public Service Commission*, 447 U.S. 557 (1980)..... 12n

Colautti v. *Franklin*, 439 U.S. 379 (1979)..... 21

Columbus Board of Education v. *Penick*, 443 U.S. 449 (1979) 10n

Committee for Public Education & Religious Liberty v. *Nyquist*, 413 U.S. 756 (1973)..... 11n

Craig v. *Boren*, 429 U.S. 190 (1976) 9n

Dayton Board of Education v. *Brinkman*, 443 U.S. 526 (1979) 10n

Dun & Bradstreet, Inc. v. *Greenmoss Builders, Inc.*, 472 U.S. 749 (1985)..... 12n

PAGE

Engel v. *Vitale*, 370 U.S. 421 (1962) 9n, 11, 21

Gertz v. *Robert Welch, Inc.*, 418 U.S. 323 (1974)..... 12n

Gideon v. *Wainwright*, 372 U.S. 335 (1963)..... 9n

Grand Rapids School District v. *Ball*, 473 U.S. 373 (1985) 10n

Green v. *County School Board*, 391 U.S. 430 (1968) ... 10n

Griffin v. *County School Board*, 377 U.S. 218 (1964) .. 12

Griswold v. *Connecticut*, 381 U.S. 479 (1965) 9n

Harris v. *McRae*, 448 U.S. 297 (1980)..... 20n

Holmes v. *Atlanta*, 350 U.S. 879 (1955) 10n

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Lemon v. *Kurtzman*, 403 U.S. 602 (1971).....9n, 10

Levitt v. *Committee for Public Education & Religious Liberty*, 413 U.S. 472 (1973) 11n

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Malloy v. *Hogan*, 378 U.S. 1 (1964) 9n

Marbury v. *Madison*, 5 U.S. (1 Cranch) 137 (1803) 8, 13

Meek v. *Pittenger*, 421 U.S. 349 (1975).....10n, 11n

Memoirs v. *Massachusetts*, 383 U.S. 413 (1966) 11n

Mergens v. *Board of Education*, 867 F.2d 1076 (8th Cir.), *cert. granted*, 109 S. Ct. 3240 (1989) 11n

PAGE

Miller v. *California*, 413 U.S. 15 (1973) 11n

Milliken v. *Bradley*, 418 U.S. 717 (1974)..... 10n

Mueller v. *Allen*, 463 U.S. 388 (1983) 11n

New York Times Co. v. *Sullivan*, 376 U.S. 254 (1964) ...9n, 11

New York Times Co. v. *United States*, 403 U.S. 713 (1971) 9n

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Pike v. *Bruce Church, Inc.*, 397 U.S. 137 (1970)..... 14n

Planned Parenthood of Central Missouri v. *Danforth*, 428 U.S. 52 (1976).....15n, 20n

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Raymond Motor Transportation, Inc. v. *Rice*, 434 U.S. 429 (1978) 14n

Reynolds v. *Sims*, 377 U.S. 533 (1964) 9n

Roberts v. *United States Jaycees*, 468 U.S. 609 (1984).. 9n

Roe v. *Wade*, 410 U.S. 113 (1973) .....*passim*

Roth v. *United States*, 354 U.S. 476 (1957) 11n

School District of Abington Township v. *Schempp*, 374 U.S. 203 (1963)..... 11n

PAGE

Shelton v. *Tucker*, 364 U.S. 479 (1960) 27

Sherbert v. *Verner*, 374 U.S. 398 (1963) 27

Swann v. *Charlotte-Mecklenburg Board of Education*, 402 U.S. 1 (1971) 10n

Texas v. *Johnson*, ____ U.S. ____, 109 S. Ct. 2533 (1989) 12n

Thornburgh v. *American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986) 16, 20n

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Wisconsin v. *Yoder*, 406 U.S. 205 (1972) 27

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PAGE

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Ill. Rev. Stat. ch. 111 § 4433 .....23, 24

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PAGE

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—v.—

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JOHN McKERNAN, GOVERNOR OF MAINE
ROY ROMER, GOVERNOR OF COLORADO
AS *AMICUS CURIAE* IN SUPPORT OF APPELLEES

Consent of Parties

Appellants and appellees have consented to the filing of this brief, and their letters of consent are being filed separately herewith.

INTEREST OF *AMICI*

Amici are Governors of ten states, and have a direct interest in any decision of this Court affecting the role of the states in the regulation of abortion. The recognition by this Court of a woman's right to terminate a pregnancy has not precluded such state regulation, and as Governors, we have been directly involved in the implementation and application of *Roe* v. *Wade* at the state level. We have a unique perspective on both the existing regulatory process and the likely consequences of its abandonment. As Governors, we are involved in all stages of the legislative process, especially in areas of broad public concern such as the regulation of abortions. We develop legislative programs and work with legislative leaders to help shape the content of laws that are finally enacted. Our state constitutional power to approve or veto bills also requires us to participate in the legislative process. Moreover, we play a unique role in the implementation of legislation, since agencies of the executive branch of state government, under our direction, are required to make day-to-day decisions in the course of administering the laws that our legislatures enact.

Charged with faithfully executing the laws of our states, we have cause for concern that the workable and restraining constitutional guidelines that have developed since *Roe* v. *Wade* may yield to laws that discriminate unfairly against large segments of our population, are easily evaded by persons with money, or are so widely ignored that even-handed enforcement becomes impossible. We are concerned about the erosion of respect for law caused by statutes, such as the Illinois provisions involved in this case, that purport to regulate health when their true purpose—restricting abortions—is apparent.

For sixteen years, since *Roe* v. *Wade*, Governors have participated in the process whereby the courts and state governments have explored and shaped the boundaries of the right of procreative choice. We do not wish to see that process dissolved by a decision of this Court abandoning the workable principles established by *Roe* and its progeny. Although the decisions of this Court have allowed healthy differences to develop among the states in the application of the fundamental right of procre-

ative choice, the core of that right, as recognized in *Roe* v. *Wade*, has been insulated from the uncertainties and shifting winds of local politics. The opinions in *Webster* v. *Reproductive Services*, however, have caused speculation as to whether the principles of *Roe* v. *Wade* will continue to provide the basis for state regulation of abortions. We are concerned that the abandonment of *Roe* would result not simply in differences among the states in the *application* of the constitutional right of procreative choice, but also in differences among the states with regard to the actual *definition* of that right—so that a woman's right to choose an abortion would be determined primarily by whether she fortuitously resides in, or has the ability to travel to, a state where abortions can be lawfully and readily obtained.

As Governors, we are not unmindful of our responsibility to enforce constitutional rights. But the definition of constitutional rights is a judicial function, and states must operate within the confines of constitutional standards established by the courts. *Roe* v. *Wade* established viability—the point during pregnancy when the fetus can survive outside the woman's body—as the point when the state interest in potential life becomes compelling. The political process cannot be permitted to establish another point in pregnancy when the State acquires a compelling interest in preserving potential life. Nor can the political process be permitted to replace "viability" with alternative concepts, such as "when life begins," or "when a person comes into being," that redefine this right. A judicial decision that purports to protect a woman's right to terminate a pregnancy, but then gives free reign to the states to define when the potential for human life begins, places upon state legislatures and Governors the responsibility for defining a federal constitutional right—properly a judicial task. Similarly, under our Constitution, it is not the function of Governors to determine whether statutes that purport to reflect a valid legislative purpose, such as the Illinois provisions at issue which purport to regulate outpatient surgical facilities generally, are actually a subterfuge for the burdensome regulation of a constitutional right. This, too, is a judicial task. From our perspective as Governors, it is obvious that if the courts do not provide workable

standards for the enforcement of a constitutional right, as this Court did in *Roe* v. *Wade*, the constitutional right will, for all practical purposes, cease to exist.

It would be unprecedented for this Court, having recognized a fundamental constitutional right, to withdraw that right and throw the abortion issue back into the political arena. It would be particularly disruptive to the process of ordered constitutional development for this Court to do so after a sixteen-year period during which courts and legislatures have worked to balance this fundamental right and the interests of the states, as the Constitution requires.

SUMMARY OF ARGUMENT

In *Roe* v. *Wade*, the Supreme Court recognized the fundamental right of women to choose to terminate a pregnancy. At the same time, the Court recognized that whenever abortion poses a threat to a woman's health, a state may impose restrictions designed to minimize or eliminate such a health risk—although during the earliest weeks of pregnancy (the period referred to in *Roe* as the "first trimester"), abortions are so safe that few, if any, such regulations can be justified on grounds of protecting health. Moreover, the Court recognized that in the latest weeks of pregnancy (the period referred to in *Roe* as the "third trimester"), once a fetus becomes viable—that is, potentially able to survive outside the woman's body—the states may protect the potential for human life by regulating and, indeed, prohibiting abortions not necessary to preserve the life or health of the pregnant woman.

Thus, the Missouri "viability testing" provision at issue in *Webster* v. *Reproductive Health Services* survived scrutiny under the principles of *Roe* v. *Wade* because that statute was found not to regulate abortions prior to the "viability" threshold in pregnancy. *See, e.g., Webster* v. *Reproductive Health Services*, ____ U.S. ____, 109 S. Ct. 3040, 3063 (1989) (O'Connor, J., concurring) ("It is clear to me that requiring the performance of examinations and tests useful to determining whether a fetus is viable, when viability is possible, and when it

would not be medically imprudent to do so, does not impose an undue burden on a woman's abortion decision. On this ground alone, I would reject the suggestion that [the Missouri statutory provision] as interpreted is unconstitutional").

Roe v. *Wade* did not "tie the hands" of state legislators. To the contrary, *Roe* instead set up a constitutional standard that has allowed the states to assert their interests while not infringing on the fundamental rights of women. Indeed, from 1973 to the present day, states have adopted legislation concerning a wide range of abortion issues, including parental consent and notification, public funding for abortions, participation of government facilities or employees in abortion procedures, and regulation of abortion facilities. Some state laws have been upheld by this Court and the lower courts, and others have been rejected. All such legislation, however, has been evaluated, both by the courts and the states, under the standards established by *Roe* v. *Wade*. Those standards have provided the states with a workable guide to the contours of the fundamental right to procreative choice.

The process engendered by *Roe*—the application by state legislatures and courts of a constitutional standard articulated by the Supreme Court—is consistent with the oldest and best traditions of this nation. It is a process that involves the judicial and political arms of the government in the uniquely American enterprise of resolving the tension between individual rights and the interests of the states and their democratic constituencies.

A decision by this Court to uphold the statutes adopted by the State of Illinois would jettison the process that has served the states so well since *Roe* was adopted in 1973. Illinois seeks to regulate abortions through a complex statutory scheme that imposes extremely burdensome requirements on private abortion clinics, and thus on the ability of women to exercise their constitutional right of procreative choice. Most critically, the statutes at issue effectively mandate for abortion clinics onerous physical plant requirements relating to the size of the facility, equipment, staffing and even air pressure—requirements that make it prohibitively expensive to open a new abortion clinic, and that few existing clinics could satisfy without extensive and costly new construction or renovation. Because, as the

District Court and the Court of Appeals found below, these requirements serve no health purpose for the safe abortion procedures performed at clinics during the period of pregnancy prior to viability, the only apparent purpose of these provisions, and their clear effect, is to limit severely the number of facilities that can perform abortions, and to make abortions too expensive and too difficult for many women to obtain during even the earliest weeks of pregnancy. Since a large percentage of abortions are performed in clinics, the Illinois provisions will sharply restrict access to abortions. For many poor women, who consist disproportionately of racial minorities, the result likely will be the effective denial of a constitutional right.

It is true, of course, that the Illinois physical plant requirements ostensibly regulate outpatient care clinics generally, rather than abortion clinics *per se*. But the broad scope of the relevant regulations does not cure their constitutional defect. The *Roe* standards will be rendered unworkable, and the right to terminate a pregnancy will be rendered meaningless, if state legislatures can simply regulate abortions under the guise of some broader category of legislative purpose that includes pre-viability abortions within its reach.

Moreover, in the case of the Illinois regulations at issue here, the courts below found that, in fact, the primary purpose of the Illinois legislature was to regulate *abortions* through the enactment of health regulations that, as far as pre-viability abortions were concerned, served no health purpose whatsoever. Indeed, by arguing that it will continue not to enforce the statutory application of these regulations to the performance of identical abortion procedures in doctors' offices, Illinois now effectively concedes that no health purpose supports the application of the regulations to abortion clinics. Certainly, to the extent that any valid health purpose, unrelated to abortion, is served by the Illinois statutes, such a purpose is pursued by means that are extremely burdensome to the right of procreative choice, rather than the least restrictive alternative, as the Constitution requires. Illinois, for example, could have exempted abortion clinics from coverage, without any detriment to patient health.

Because the statutes at issue serve no health purpose for abortions in the early phases of pregnancy, they can be upheld only if this Court recognizes some sufficient state interest, other than protection of a woman's health, for regulating abortion from the moment of conception. But the State of Illinois, relying only on an asserted health purpose that the record does not support and lower courts have rejected, suggests no other purpose to justify its regulation of early-stage abortions. Moreover, to regulate pre-viability abortions for some reason other than protection of a woman's health would directly violate the principles of, and effectively overrule, *Roe* v. *Wade*—a goal that the State of Illinois purportedly disavows in this case.

To uphold the challenged Illinois regulations would thus destroy the workable "viability" standard adhered to by this Court, and relied on by state legislatures, since *Roe* was decided. The viability standard reflects the biological realities of pregnancy—biological realities that have not changed since *Roe* was adopted and that will not change in the future. It is now beyond dispute, as confirmed by the scientific community, that prior to approximately the twenty-third or twenty-fourth week of pregnancy, there is no possibility of fetal survival outside the womb. Prior to viability, there can accordingly be no basis for asserting an interest in the fetus that is separate from, and paramount to, the interests of the pregnant woman.

To abandon the workable standards established in *Roe* would not only depart from this Court's unbroken line of precedent in its abortion cases, but more importantly would ignore 200 years of constitutional history. Fundamental rights usually achieve constitutional protection in the face of intense political opposition and hostility. Never in its history has this Court turned its back on a right it has previously recognized, leaving the protection of that right subject to the uncertain and divisive mercies of the majority, or an influential minority, in particular states.

States serve as laboratories for applying, and exploring the contours of, the right of procreative choice—a right crucial to the lives of millions of American women, and men. American constitutional law, however, requires that the courts, and particularly this Court, define the standards by which that fundamental right shall be protected. To sustain the Illinois statute at

issue here would rip the *Roe* framework asunder and throw back into the political arena an issue whose dimensions have until now been narrowed and made workable, to the benefit of the states, by the prior decisions of this Court.

The decision of the Seventh Circuit Court of Appeals should be affirmed, and *Roe* v. *Wade* should not be abandoned.

ARGUMENT

I.

FOLLOWING THE RECOGNITION BY THIS COURT OF A WOMAN'S RIGHT TO TERMINATE A PREGNANCY, STATE LEGISLATURES HAVE PARTICIPATED WITH COURTS IN THE TRADITIONAL PROCESS OF PROBING THE BOUNDARIES OF THAT RIGHT, SUBJECT TO FINAL DEFINITION BY THIS COURT.

A. Throughout Our History, Courts and Legislatures Have Shaped the Development of Constitutional Law by Performing Their Respective Constitutional Functions.

Chief Justice Marshall's opinion in *Marbury* v. *Madison* defined clearly the role of the judiciary in constitutional adjudication: "It is emphatically the province and duty of the judicial department to say what the law is." 5 U.S. (1 Cranch) 137, 177 (1803). At the same time, the *Marbury* opinion carved out an important role for elected legislatures: a court can only decide "what the law is" when there is a specific "case or controversy" concerning a particular legislative enactment. The adoption and enforcement of legislation has thus evolved as a principal means of creating the legal controversies that invoke the broad judicial power proclaimed in *Marbury* as inherent in a written constitution. This model of judicial power eschews advisory opinions based on hypothetical facts and relies instead on the political arms of government, primarily state legislatures, to provide the grist for the constitutional mill.

The current abortion controversy, which has brought to this Court a series of state laws enacted since *Roe* v. *Wade* was

decided in 1973, is the latest manifestation of a process that has marked nearly two hundred years of constitutional development. This process involves a case-by-case evolution of the law in which the courts recognize, define, and enforce constitutional rights, and legislatures, responding to judicial action, probe the boundaries of these rights, subject to further definition by the courts and, ultimately, by this Court. As a result of this process, profound differences among our people, often reflected in constitutional disputes, gradually achieve a resolution that is woven into the nation's constitutional fabric. Among the more prominent recent examples are cases involving the rights of racial minorities,[1] gender discrimination,[2] the relationship between government and religion,[3] the rights of criminal defendants,[4] the structure of legislative bodies,[5] issues of free expression,[6] and the right of procreative choice.[7]

In each of these areas the recognition by this Court of a constitutionally protected right did not foreclose the involvement of the political arms of government in the continuing process of constitutional evolution. Instead, decisions of this Court stimulated new statutes addressing issues not resolved by those decisions, leading in turn to new decisions by this Court further defining the limits both of individual rights and of governmental power. In each instance there gradually emerged an area of constitutionally protected liberty that was shielded from the political process, as well as an area that was left to democrati-

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1 *See, e.g.*, *Brown* v. *Board of Education*, 347 U.S. 483 (1954).

2 *See, e.g.*, *Craig* v. *Boren*, 429 U.S. 190 (1976); *Roberts* v. *United States Jaycees*, 468 U.S. 609 (1984).

3 *See, e.g.*, *Lemon* v. *Kurtzman*, 403 U.S. 602 (1971); *Engel* v. *Vitale*, 370 U.S. 421 (1962).

4 *See, e.g.*, *Gideon* v. *Wainwright*, 372 U.S. 335 (1963); *Malloy* v. *Hogan*, 378 U.S. 1 (1964).

5 *See, e.g.*, *Reynolds* v. *Sims*, 377 U.S. 533 (1964).

6 *See, e.g.*, *New York Times Co.* v. *Sullivan*, 376 U.S. 254 (1964); *New York Times Co.* v. *United States*, 403 U.S. 713 (1971).

7 *See, e.g.*, *Griswold* v. *Connecticut*, 381 U.S. 479 (1965); *Roe* v. *Wade*, 410 U.S. 113 (1973).

cally elected legislators and executives. Courts have thus narrowed the political playing field, but not to the exclusion of the political players.

For example, in *Brown* v. *Board of Education*, 347 U.S. 483 (1954), this Court held that state-mandated segregated education deprived black children of equal protection of the laws. Following that decision, the colloquy between the political and judicial arms of government moved on to a new range of issues not directly at issue in *Brown*: the validity of segregation in other types of public facilities;[8] the extent to which *Brown* imposed an affirmative obligation to cure the effects of prior mandated segregation;[9] the applicability of *Brown* to northern cities with no history of formal mandated racially separate schools;[10] the appropriate standards of proof;[11] the nature of the remedy;[12] and the point in time when a previously segregated school system can emerge from federal court jurisdiction and be treated as a system free from the taint of its prior history.[13]

Similarly, *Lemon* v. *Kurtzman*, 403 U.S. 602 (1971), held that direct financial aid to religious elementary and secondary schools, in the form of supplements to teachers' salaries, violated the Establishment Clause; yet the contours of Jefferson's "wall of separation" between church and state have been the subject of legislation and court decisions ever since. This Court has ruled on the constitutionality of programs designed to diagnose learning disabilities,[14] programs of remedial education,[15]

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8 *See, e.g., Holmes* v. *Atlanta*, 350 U.S. 879 (1955).

9 *See, e.g., Green* v. *County School Board*, 391 U.S. 430 (1968).

10 *See, e.g., Keyes* v. *School District*, 413 U.S. 189 (1973).

11 *Id. See also Washington* v. *Davis*, 426 U.S. 229 (1976); *Columbus Board of Education* v. *Penick*, 443 U.S. 449 (1979); *Dayton Board of Education* v. *Brinkman*, 443 U.S. 526 (1979).

12 *See, e.g., Swann* v. *Charlotte-Mecklenburg Board of Education*, 402 U.S. 1 (1971); *Milliken* v. *Bradley*, 418 U.S. 717 (1974).

13 *Pasadena City Board of Education* v. *Spangler*, 427 U.S. 424 (1976).

14 *Wolman* v. *Walter*, 433 U.S. 229 (1977).

15 *Meek* v. *Pittenger*, 421 U.S. 349 (1975); *Grand Rapids School District* v. *Ball*, 473 U.S. 373 (1985); *Aguilar* v. *Felton*, 473 U.S. 402 (1985).

enrichment programs,[16] the costs of testing,[17] and tax deductions and credits for parents of children attending religious schools.[18] The same type of pattern has emerged after this Court's decision in *Engel* v. *Vitale*, 370 U.S. 421 (1962), proscribing state-mandated prayers in the public schools. Bible-reading and recitation of the Lord's Prayer,[19] setting aside a moment for "silence or prayer,"[20] and, currently, allowing "equal access" for student religious clubs,[21] have all tested the limits of this Court's original decision in *Engel*. Few have been satisfied with all of the judicial decisions in this area. But to have left the entire subject of religious practices in public schools, and financial support of religious schools, to the pressures of political majorities, or influential religious minorities, would have served neither the educational needs of children and parents, the interests of individual rights, nor the political institutions of this country.

Both the obscenity and libel areas of First Amendment law have witnessed similar patterns of constitutional development. In 1957 this Court, in ruling that obscenity was not constitutionally protected, initiated the difficult task of defining the meaning of obscenity as part of the process of giving adequate scope to literary and artistic expression.[22] In *New York Times Co.* v. *Sullivan*, 376 U.S. 254 (1964), defamation actions by

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16 *Meek* v. *Pittenger*, 421 U.S. 349 (1975).

17 *Levitt* v. *Committee for Public Education & Religious Liberty*, 413 U.S. 472 (1973); *Wolman* v. *Walter*, 433 U.S. 229 (1977).

18 *Committee for Public Education & Religious Liberty* v. *Nyquist*, 413 U.S. 756 (1973); *Mueller* v. *Allen*, 463 U.S. 388 (1983).

19 *School District of Abington Township* v. *Schempp*, 374 U.S. 203 (1963).

20 *Wallace* v. *Jaffree*, 472 U.S. 38 (1985).

21 *Bender* v. *Williamsport Area School District*, 475 U.S. 534 (1984); *Mergens* v. *Board of Education*, 867 F.2d 1076 (8th Cir.), *cert. granted*, 109 S. Ct. 3240 (1989).

22 *Roth* v. *United States*, 354 U.S. 476 (1957). *See also Memoirs* v. *Massachusetts*, 383 U.S. 413 (1966); *Miller* v. *California*, 413 U.S. 15 (1973); *Jenkins* v. *Georgia*, 418 U.S. 153 (1974).

public officials were subjected to significant First Amendment restraints, leading to the constitutionalization of an area of law hitherto thought to be a matter of exclusive state concern.[23] In both areas this Court first staked out the boundaries of First Amendment protection, followed by the involvement of the states and the judiciary in the ongoing process of further defining the contours of protected speech. The recently recognized rights of commercial speech[24] and expressive conduct[25] are now evolving along a similar pattern.

This gradual process of constitutional development has been replicated in every area involving constitutionally protected rights. The case-by-case and statute-by-statute development of constitutional doctrine has enabled both the political and judicial branches of government to fulfill their respective constitutional roles of responsibly representing the wishes of the people, and vigorously protecting the constitutional rights of individuals and disfavored groups. Essential to this process of constitutional development is the retention by the courts of their ultimate power to define the meaning and scope of constitutional rights. Some state legislative enactments may generate litigation that gives rise to further definition of the constitutional standards that courts establish, but courts alone have the "province and duty . . . to say what the law is." Yielding this function to the states effectively eradicates the right that the judicial branch is supposed to define and to protect. Until *Griffin* v. *County School Board*, 377 U.S. 218 (1964), for example, it was not clear whether *Brown* left the states free to escape its strictures by substituting state-assisted private academies for the public school system. To have allowed the states to define the permissible limits of their own involvement in segregated

23 *See, e.g., Gertz* v. *Robert Welch, Inc.*, 418 U.S. 323 (1974); *Dun & Bradstreet, Inc.* v. *Greenmoss Builders, Inc.*, 472 U.S. 749 (1985).

24 *See, e.g., Virginia State Board of Pharmacy* v. *Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748 (1976); *Central Hudson Gas & Electric Corp.* v. *Public Service Commission*, 447 U.S. 557 (1980); *Posadas de Puerto Rico Assoc.* v. *Tourism Co. of Puerto Rico*, 478 U.S. 328 (1986).

25 *See, e.g., United States* v. *O'Brien*, 391 U.S. 367 (1968); *Buckley* v. *Valeo*, 424 U.S. 1 (1976); *Texas* v. *Johnson*, _____ U.S. _____, 109 S. Ct. 2533 (1989).

education would have allowed them to define the scope of the right recognized in *Brown*. Neither *Brown* nor the judicial role envisioned in *Marbury* v. *Madison* would have survived.

The Illinois regulations in this case place in equally sharp focus the proper role of the states and the courts in the process of constitutional development. These regulations impose burdensome restrictions on a woman's access to an abortion during the early stages of pregnancy. The only purpose asserted by Illinois to justify these regulations is a purported interest in the health of the pregnant woman. As applied to early-stage abortions, however, the District Court and Court of Appeals found that these regulations serve no valid health purpose whatsoever.[26] The only other conceivable purpose would be the state's interest in preserving the potential for human life. *Roe* v. *Wade*, however, established viability as the point at which that interest becomes sufficiently compelling to justify burdensome abortion regulations. Since the Illinois provisions regulating outpatient clinics apply to abortions performed during the early stages of pregnancy, upholding these regulations as a constitutionally valid regulation of abortions would require judicial determination that states, rather than courts, can define the point when the state's interest in the potential for human life is compelling. For the courts to turn that determination over to the states would constitute a sharp departure from the process by which the courts and the states function together, each in their own realm, to contribute to the development of constitutional rights.

Equally destructive of the proper role of the courts and states in the process of constitutional development would be the acceptance of Illinois' contention that its regulations are concerned with outpatient surgical facilities rather than abortions. It is for the judiciary, not the states, to determine whether statutes enacted ostensibly for reasons of health have the purpose and effect of regulating a constitutionally protected activity, as the Circuit Court found the Illinois statutes do.[27] State statutes

26 *Ragsdale* v. *Turnock*, 841 F.2d 1358, 1368 (7th Cir. 1988). *See also Ragsdale* v. *Turnock*, 625 F. Supp. 1212, 1230 (N.D. Ill. 1985).

27 *Ragsdale* v. *Turnock*, 841 F. 2d 1358, 1369 (7th Cir. 1988).

that claim to regulate health or safety, for example, have been carefully scrutinized by this Court since the era of Chief Justice Marshall to determine whether their purpose and effect was to discriminate against interstate commerce.[28] No lesser scrutiny is required in this case.

Because of its destructive and irrational impact on a woman's access to an abortion during the period prior to the point of viability, the Illinois statute at issue in this case poses a direct and unavoidable challenge to the right to terminate a pregnancy recognized in *Roe* v. *Wade*. Never before in our history has this Court, after recognizing a fundamental right, taken that right away and thrown the entire subject into the political arena.

B. *Roe* v. *Wade* Provided the States and the Courts with Workable Standards for the Regulation of Abortion.

1. The *Roe* standards, premised on "viability," emerged in an active case and controversy that required this Court to balance state interests and the fundamental rights of women.

This Court's decision in *Roe* did not arise in a vacuum. Rather, this Court faced an active case and controversy that arose following the powerful movement of women toward full citizenship and participation in all aspects of our society. The social, intellectual and political developments of the 1960's and 1970's gave rise to women's active pursuit of reproductive freedom. As massive numbers of women entered the workplace and women emerged as participants in such areas as business and government, women and men came to recognize that state statutes restricting access to abortion not only limit a fundamental right to procreative choice, but also infringe on the ability of women to enjoy full and equal participation in American society. Such full and equal participation is only possible if women can decide for themselves whether and when to bear children.

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28 An early example was *Willson* v. *Black Bird Creek Marsh Co.*, 27 U.S. 245 (1829). More modern examples include *Baldwin* v. *G. A. F. Seelig, Inc.*, 294 U.S. 511 (1935); *Raymond Motor Transportation, Inc.* v. *Rice*, 434 U.S. 429 (1978); *Pike* v. *Bruce Church, Inc.*, 397 U.S. 137 (1970).

At the same time, the very state abortion statutes that came under challenge reflected, at least in part, state interests in protecting potential life and the health of pregnant women. The case and controversy in *Roe* thus required this Court to play its traditional role of balancing fundamental personal liberty and legitimate state interests—in that case the fundamental right of women to procreative choice and the state's interests in protecting potential life and the health of pregnant women.[29] *Roe* presented the Court with a difficult challenge; but the difficulty of that challenge did not render *Roe* an aberration in judicial history. Indeed, in *Roe* and its progeny, this Court and the lower courts have established the standards for judging stat abortion statutes and whether such statutes impermissibly burden women's fundamental rights.

2. A constitutional standard based on viability emerged as the most appropriate way to balance the fundamental right to procreative choice and the states' legitimate interests in protecting potential life and the health of pregnant women.

After considering the rights and state interests implicated by the Texas abortion statute at issue in *Roe*, the Court recognized that a principled distinction, rooted in the biological realities of pregnancy, can be drawn between the state's interest in the fetus during the early and later stages of pregnancy. Indeed, it is well-established that there exists an immutable biological threshold

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29 As Justice Blackmun has explained for this Court:

> In *Roe* v. *Wade* the Court concluded that the "right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, as we feel it is, or, as the District Court determined, in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." 410 U.S., at 153. It emphatically rejected, however, the proffered argument "that the woman's right is absolute and that she is entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses." *Ibid.* Instead, this right "must be considered against important state interests in regulation." *Id*., at 154.

Planned Parenthood of Missouri v. *Danforth*, 428 U.S. 52, 60-61 (1976).

in pregnancy—approximately the twenty-third or twenty-fourth week of pregnancy—prior to which a fetus cannot survive outside of the womb.[30] Prior to that threshold, crucial bodily organs—including the brain, the kidney and the lungs—are not yet sufficiently matured to provide the mutually sustaining functions that are a prerequisite to extrauterine survival.

At the same time, the Court recognized that a principled distinction can be drawn between the state's interest in protecting the health of pregnant women during the early and later stages of pregnancy. While abortion procedures in the latest stages of pregnancy can present a health risk, there is no dispute that abortion procedures during the early stages of pregnancy are so safe that virtually no state regulation can be justified on grounds of protecting the health of pregnant women.

The biological threshold in pregnancy—which *Roe* referred to as the "viability" point—thus emerged as an appropriate focal point for balancing the right to procreative choice and the state interests in potential life and in the health of pregnant women. Just as a viability standard could reflect the safety of abortion procedures during the early stages of pregnancy, a standard based on viability could also reflect the difference between "the state interest in protecting the freshly fertilized egg and the state interest in protecting the 9-month-gestated, fully sentient fetus on the eve of birth." *Thornburgh* v. *American College of Obstetricians & Gynecologists*, 476 U.S. 747, 770 (1986) (Stevens, J., concurring).

Indeed, before the threshold point of viability, a fetus is biologically an inseparable part of a pregnant woman and unable to survive outside of her womb; before viability, any life potential of the fetus is absolutely dependent upon the woman who will bring the fetus to a point at which independent survival becomes possible. No compelling state interest in the fetus as a

30 *See, e.g.*, *Fetal Extrauterine Survivability*, Report to the New York State Task Force on Life and Law 9 (1988) ("After reviewing the developmental biology of several crucial fetal organs, including the brain, the kidneys, and the lungs, the Committee concluded that a point exists before which the fetal organs are too immature to function, even with the assistance of sophisticated medical technology. This point in time is 23-24 weeks of gestation; prior to that time, fetal life cannot be maintained outside the womb.").

"person," or a "potential life," can thus exist from the moment of conception, because prior to viability it is not possible to define an interest in a fetus distinct from the woman with whose body the fetus is inextricably linked.

Moreover, the viability standard is fully supported by science. The biological facts upon which the viability standard is based have not changed since 1973, nor will any technological advance change those biological facts. Today, as is universally recognized by the scientific community, "no technology exists to bridge the development gap between the three-day embryo culture and the 24th week of gestation." *Fetal Extrauterine Survivability*, Report to the New York Task Force on Life and the Law 3 (1988). No technology exists that could, for example, support lung functions prior to the development of the lungs that has occurred at the biological threshold of viability; even the development of artificial lung coatings "has not changed the lower boundary of gestational age at which newborns can survive." *Id.* at 8. Indeed, today "[n]eonates less than 24 weeks gestational age have close to a 0% survival rate." *Id.* at 10.

It thus remains true, as in 1973, that "before [the threshold of development occurs], the fetal organs, especially the lungs, are not sufficiently developed to permit extrauterine survival even with the most sophisticated technology currently available." *Id.* at 12. And it remains mere "science fiction" even to speculate about technological advances that might shift the extrauterine survivability point to a time in pregnancy prior to the biological threshold. Talk of technology for the pre-threshold period presupposes a scientific knowledge of the complex fetal development process which does not yet exist and is not even contemplated for the foreseeable future.[31] Nor, in

31 Though science and technology are interrelated, scientific developments—the understanding of biology or nature—must precede the application of technology to any such understanding. Basic scientific research, however, has not even approached an understanding of the complex developmental process prior to the biological threshold. *See, e.g.*, H. Hoshi, M. Kan and W.L. McKeehan, *Direct Analysis of Growth Factor Requirements for Isolated Human Fetal Hepatocytes*, 23 In Vitro Cell Devel-

any event, could such technology ever create a potential for life outside a womb prior to the biological threshold point. Any such technology could never give the fetus the functional organs necessary to make extrauterine survival possible.[32]

It is true, as this Court has recognized, that, in fact, the medical risks of various abortion procedures, including those used during the middle months of pregnancy, have decreased since *Roe* was decided in 1973. *See Akron* v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 435-36 (1983); *see also id.* at 454-55 (O'Connor, J., dissenting).[33] However, no technology has or will move the potential for survival outside the womb before the point when the biological threshold has been crossed. Thus, as the scientific community recognizes, "[i]n the foreseeable future, it is likely that technological

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opmental Biology 723-32 (1987); J.R. Bickenbach and K.A. Holbrook, *Proliferation of Human Embryonic and Fetal Epidermal Cells in Organ Culture*, 177 Am. J. Anat. 97-106 (1986); Moore and Walsh, *Specific regulation of N-CAM/D2-CAM cell adhesion molecule during skeletal muscle development*, 4 Embo. J. 623-30 (1980); Holmes, *Morphological and physiological maturation of the brain in the neonate and young child*, 3 J. Clin. Neurophysiology 207-38 (1986).

32 In the post-threshold period, there is a potential for fetal survival outside a womb because fetal organs are sufficiently developed to perform bodily functions. Post-threshold technology thus can assist the fetus' *own* organs to perform those bodily functions themselves. *See, e.g.*, C.R. Austin and R.U. Short, *Embryonic and Fetal Development* 77 (1972). For example, while in the latter stages of pregnancy, oxygen is provided to the fetus by the placenta and the lungs of the fetus do not themselves "breathe" inside the woman's body, after the biological threshold point, that same fetus might be assisted by a respirator so that its lungs could start to breathe outside the womb. Conversely, in the pre-threshold period there is no similar potential for fetal survival outside a womb because there are no functional fetal organs which would be able to perform bodily functions—that is, there are no functional organs that technology could even assist.

33 Indeed, the predicate scientific knowledge on which safe abortion procedures are based *has* advanced to the point where technology has now developed to make abortion safe well into the middle months of pregnancy, *see Akron*, 462 U.S. at 435-36.

advances in the care of newborns will enhance survival at each gestational age above 24 weeks, but will not lower the threshold for fetal extrauterine survival." *Fetal Extrauterine Survivability*, *supra*, at 12.

3. The viability standard has proven workable for the states and the courts.

Since 1973, *Roe* has provided workable standards for the states and the courts, while allowing women to exercise their right to procreative choice.

The *Roe* standards, of course, have not precluded state regulation of abortion.[34] Moreover, the states have been able to understand the principles articulated by this Court in *Roe* and its progeny. The Missouri "viability testing" provision at issue in *Webster*, reflecting the Missouri legislature's recognition of *Roe*'s viability standard, is just one example of a state statute that applies different regulations in the early and later stages of pregnancy.[35]

The *Roe* standards have also proven workable for the courts. While certain courts have expressed disagreement with the con-

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34 States have adopted abortion regulations relating to such matters as licensing of persons who perform abortions (*see, e.g.*, Alaska Stat. § 18.16.010(a)(1) (1986); Ark. Stat. Ann. § 5-61-101 (1987); Fla. Stat. Ann. § 390.001(3) (West 1986); Ga. Code Ann. § 16-12-141(a) (1988); Haw. Rev. Stat. § 453-16(a)(1) (1985); Mo. Ann. Stat. § 188.020 (Vernon Supp. 1989); Mont. Stat. Ann. § 50-20-109(1)(a) (1987); Neb. Rev. Stat. § 28-335 (1985); Nev. Stat. § 442.250(1)(a) (1987); Va. Code Ann. § 18.2-72 (1988)) and reporting requirements (*see, e.g.*, Ark. Stat. Ann. § 20-18-603 (1987); Ga. Code Ann. § 1612-141(d) (1988); Idaho Code § 39-261 (1985); Ill. Ann. Stat. ch. 38 § 81-30, 30.1 (1975); Minn. Stat. Ann. § 145.413 (West 1989); Mo. Ann. Stat. § 188.052 (Vernon Supp. 1989); Mo. Ann. Stat. § 188.055 (Vernon Supp. 1989); Nev. Stat. § 442.265 (1987); Tenn. Code Ann. § 39-4-203 (1986); Va. Code Ann. § 82:1-264 (1985); Wash. § 43.20A.625 (1982); W. Va. Code Ann. § 16-2F-6 (1984); Wisc. Stat. § 69.186 (West Supp. 1988); Wyo. Stat. Ann. § 35-6-108 (1988)).

35 *See, e.g.*, Ark. Stat. Ann. § 20-16-705 (1987); Ill. Ann. Stat. ch. 38 § 81-26(2)(a) (Smith-Hurd 1975); Ind. Code Ann. § 35-1-58.5-7 (1986); Ky. Rev. Stat. Ann. title 18 § 311.780 (1983); La. Rev. Stat. Ann. A § 14:87.5 (1985), § 40:1299.35.4 (Supp. 1989); Mont. Stat. Ann. § 50-20-109(1)(c) (1987); Neb. Rev. Stat. § 28-329 (1985); Okla. Stat. Ann. title 63 1-732.

clusions reached in *Roe*, no court has been unable to apply the *Roe* standards on grounds that they are either unclear or unworkable. Thus, for example, the "viability testing" provision adopted by Missouri survived constitutional scrutiny in *Webster* through application of the *Roe* principles. *See Webster*, ____ U.S. ____, 109 S. Ct. 3040, 3063 (1989) (O'Connor, J., concurring) (requiring the performance of examinations and tests useful to determining whether a fetus is viable, when it would not be medically imprudent to do so, "does not impose an undue burden on a woman's abortion decision"). Indeed, the standards of *Roe* have been consistently applied by this Court in cases involving spousal consent,[36] parental consent to abortions for minors,[37] requirements unrelated to maternal health for pre-viability abortions,[38] mandatory dissemination of information relating to abortions,[39] and federal and state funding for abortion procedures.[40]

Perhaps most importantly, the viability standard has afforded ample time for most women to exercise a considered and informed procreative choice after learning of their pregnancies and relevant attendant conditions. Indeed, it has remained true since 1973 that only an extremely small number of abortions are obtained during the period after the viability threshold. In fact, less than 1 percent of all abortions are obtained after 21 weeks of pregnancy, and only .01 percent

36 *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52 (1976).

37 *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52 (1976); *Bellotti* v. *Baird*, 443 U.S. 622 (1979); *Akron* v. *Akron Center for Reproductive Health*, 462 U.S. 416 (1983).

38 *Akron* v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983).

39 *Thornburgh* v. *American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986); *Akron* v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983).

40 *Webster* v. *Reproductive Health Services*, ____ U.S. ____, 109 S. Ct. 3040 (1989); *Harris* v. *McRae*, 448 U.S. 297 (1980); *Maher* v. *Roe*, 432 U.S. 464 (1977).

occur after 24 weeks.[41] And where such "late" abortions have occurred, there have been compelling reasons, such as the development of a life-threatening condition in the pregnant woman, that justify and explain the timing of the abortion decision.[42]

Moreover, the flexibility of the viability standard has contributed to its workability. Each individual doctor, within the privacy of the doctor-patient relationship, can make an individualized determination about when the fetus is viable—a determination that is most appropriately made on a case-by-case basis. *See Colautti* v. *Franklin*, 439 U.S. 379 (1979); *Webster*, 109 S. Ct. at 3062 (O'Connor, J., concurring) (the Missouri "viability testing" provision only "require[s], when not imprudent, the performance of 'those tests that are useful to making *subsidiary* findings as to viability'. . . . Thus, consistent with *Colautti*, viability remains the 'critical point' under [the provision]").

That a majority, or a vocal minority, in certain states have opposed the decision in *Roe* does not justify abandoning the constitutional standards *Roe* set forth. Mere public disagreement with a court decision does not render the decision unworkable or "political." Were such the case, this Court would have been forced to abandon its decisions mandating school desegregation (*Brown* v. *Board of Education*) and barring prayer in public schools (*Engel* v. *Vitale*), among others. Indeed, consti-

41 *See, e.g.*, Henshaw, Binkin, Blaine & Smith, *A Portrait of American Women Who Obtain Abortions*, 17 Family Planning Perspectives 90, 91 (1985); Spitz, Lee, Grimes, Schoenbucher & Lavorie, *Third Trimester Induced Abortion in Georgia, 1979 and 1980*, 73 Am. Journal of Public Health 594 (May 1983) (abortions after 24 weeks may have accounted for only .004 percent of all abortions in Georgia in 1979 and 1980); Grimes, *Second Trimester Abortions in the United States*, 16 Family Planning Perspectives 260 (1984) (while in 1973 only 63 percent of all abortions occurred within the first 10 weeks of pregnancy, today 88 percent of abortions occur in the first 10 weeks).

42 *See* Hunter, *"Time Limits on Abortion," Reproductive Laws for the 1990's: A Briefing Handbook* 106, 129 (N. Taub and S. Cohen, eds. 1988); Nsiah-Jefferson, *"Reproductive Laws, Women of Color and Low-Income Women," Reproductive Laws for the 1990's: A Briefing Handbook* 23 (N. Taub and S. Cohen, eds. 1988).

tutional rights would be rendered meaningless if not subject to court protection in the face of public pressure to curtail those rights. That the abortion issue presents the states and the courts with a difficult challenge does not move the fundamental right of procreative choice outside of our constitutional scheme.

II.

THE BOUNDARIES OF THE CONSTITUTIONAL RIGHT TO DECIDE WHETHER TO BEAR A CHILD DO NOT ENCOMPASS EITHER THE ABORTION-SPECIFIC PARTS OF THE ILLINOIS REGULATIONS OR THE APPLICATION OF THE GENERAL REGULATIONS TO ABORTION CLINICS, SO THAT THE INJUNCTION BELOW IS PROPER AND SHOULD BE AFFIRMED.

The Illinois regulations at issue in this case unconstitutionally burden the fundamental right of women to terminate a pregnancy within the standards set by *Roe* v. *Wade*, 410 U.S. 113 (1973)—standards that remain valid even after this Court's decision in *Webster* v. *Reproductive Health Services*, 109 S. Ct. at 3062 (O'Connor, J., concurring) ("I do not think . . . § 188.029 . . . imposes a degree of state regulation on the medical determination of viability that in any way conflicts with prior decisions of this Court.") Indeed, Illinois itself now claims that its regulations can be upheld by applying the presumably valid standards of *Roe* v. *Wade*. *See* Brief for Appellants at 23.

On their face, however, the Illinois provisions at issue are clearly unconstitutional under the *Roe* standards Illinois purports to accept. Perhaps in recognition of that fact, the State of Illinois now attempts to narrow the issues in this case by asserting, for the first time, a policy of non-enforcement of several key provisions of the regulations that were struck down by the courts below. *See* Brief for Appellants at 6-8. Even if Illinois' present posture on non-enforcement is accepted at face value, as it should not be at this stage of the litigation, the statutes and regulations at issue nonetheless unduly burden—indeed may absolutely prevent—the provision of abortion services by appellees and by similarly situated existing and potential abortion clinics. Nor are these regulations justified by any state interest whatsoever in the health of women making use of the services provided.

A. The Illinois Provisions on Their Face Unconstitutionally and Directly Burden the Fundamental Right of Choice, and Are Justified by No Countervailing State Interest.

Despite efforts to obfuscate the issue, the stark fact is that the Illinois statutes (and accompanying regulations) are aimed at, and directly impact, the right of women to choose, after the onset of pregnancy, whether to continue a pregnancy to term.

Thus, § 16-1 of the Illinois Medical Practice Act (Ill. Rev. Stat. ch. 111 § 4433) (MPA) authorizes the Department of Regulation to suspend the license of any physician who performs any abortion outside a hospital or a licensed Ambulatory Surgical Treatment Center (ASTC) that meets the detailed and prolix requirements established by the ASTC Act (Ill. Rev. Stat. ch. 111-1/2, § 157-8.1 *et seq.*) and related regulations. No health interest has ever been, or could possibly be, asserted for this abortion-specific requirement. Indeed, induced abortion is one of the most common clinical procedures performed today, and one of the safest that physicians currently perform. *See* Brief of the American College of Obstetricians and Gynecologists, *et al.*, as *Amicus Curiae* in Support of Appellees, and sources cited. The notion that there is a special health reason for singling out abortions in this manner is plainly contradicted by Illinois' position, now asserted in this Court, that the State will not attempt to enforce the provisions to prohibit the performance of the abortion procedure in any physician's office.

The burden imposed by the requirement of § 16-1 of MPA, and its purpose to interfere with the abortion procedure for no permissible reason, is also made apparent by the provisions of the ASTC Act, to which § 16-1 refers, and with which it is integrated. That statute also singles out abortion by defining the covered centers as those "*devoted primarily* to the maintenance and operation of facilities for the performance of surgical procedures *or any facility in which a medical or surgical procedure*

is utilized to terminate a pregnancy irrespective of whether the facility is devoted primarily to this purpose." Ill. Rev. Stat. ch. 111 § 4433 (emphasis added). Moreover, these statutory requirements were written in the context of a statutory scheme under which they applied *only* to early pregnancy abortions, because after the first twelve weeks of pregnancy, abortions were required to take place in full-care hospitals (a provision which the Court of Appeals below held to be moot). *Ragsdale* v. *Turnock*, 841 F.2d 1358, 1376 (7th Cir. 1988). Again, there is simply no supportable health interest justifying these abortion-specific provisions, whether that interest be termed compelling, important, substantial, or even rational.

These provisions are fortified by the requirement in the Health Facilities Act (Ill. Rev. Stat. ch. 111-1/2, § 115, *et. seq.*) that ASTC's obtain certificates of need prior to constructing, relocating, or renovating their facilities. The effect of this requirement is to force physicians like appellee Ragsdale, whom the record shows to have been personally the target of public intimidation, to submit to lengthy and intense public hearings before being permitted to provide early-pregnancy abortion services. This also is plainly a burden placed upon the provision of such services which is not justified by any interest of the state in the protection of the health of the women affected.

The District Court found as a matter of fact, based on the testimony of Dr. Ragsdale and others, that these provisions of Illinois law "chill" health care providers from offering abortions, and that their impact on women seeking abortions is "enormous," because they "increase the cost of abortions and decrease their availability," making it "extremely difficult, if not impossible, for those desiring to perform abortion services to construct a facility or move to a new location." 625 F.Supp. 1212, 1225-1335 (N.D. Ill. 1985). The cumulative effect is to "place a very real and a very heavy burden on the right of a woman to decide to terminate her pregnancy." *Id.* at 1227. These findings were accepted by the Court of Appeals, and having the support of the two courts below, should be given full weight in this Court.

Amici are deeply interested in preserving the full scope of the power of the States to enact and enforce measures designed to

protect the health of their citizens. But they are equally interested in not having measures unrelated to health needs legitimated in the name of health, with resulting disrespect for the process and rule of law. Here the burden found by the courts below to be placed on women seeking to exercise their fundamental right of choice is not balanced by any health interest whatsoever. It bears repeating that this central fact is fortified by the State's position in this Court that it sees no need for the regulation of abortion procedures performed in physicians' offices. It follows that there cannot be any need to apply the regulations to ASTC-like facilities.

The courts below held that the burden placed on women by the Illinois statutes and regulations at issue, and the lack of any showing of a balancing interest in the health of the women affected, justified the preliminary injunction issued by the District Court. There is no basis for overturning that decision. To the extent that the position of the State is changed in this Court by its asserted policy of non-enforcement of key sections of the statutes and regulations, that is a matter which can best be evaluated not in this Court, but by the courts below in their consideration of the question whether to make the injunction permanent.

The State here attempts to justify the regulatory scheme at issue on the grounds that it is concerned with the health issues arising from the increased use of out-patient clinics for various surgical procedures, not with abortions alone, so that the abortion clinics simply happen to be regulated along with the others. As we have shown, that is simply not so with respect to the statutes on their face, which are abortion-specific on key matters. In any event, the preliminary injunction at issue here is directed at the enforcement of the regulation of ASTC's only to the extent that such regulation prohibits or prevents the opening or operation of abortion clinics as such—that is to say, facilities such as those of appellees, which are intended to offer only abortion and abortion-related services for early pregnancies. By failing to exempt from its regulations those facilities devoted almost exclusively to abortion and abortion-related procedures in the early stages of pregnancy, Illinois has pursued regulation of clinics performing few or no abortions by a means that

imposes an onerous burden on women's right to procreative choice, instead of the least restrictive means, as the Constitution requires.

B. The Illinois ASTC Requirements Cannot Be Justified As Applied to Abortion Clinics.

The abortion-specific provisions of the Illinois statutory scheme, as discussed above, clearly are unconstitutional. *Amici* have no quarrel in this case with the Illinois ASTC's *non*-abortion-specific regulations as applied to clinics offering general out-patient surgical procedures, even though such clinics (as well as hospitals) may be the facilities of choice for some women desiring to terminate early pregnancies. However, the application of these non-abortion-specific regulations to abortion clinics is unconstitutional.

There can be no doubt that the application of the ASTC requirements to abortion clinics burdens the providers of abortion services.[43] The courts below found as a fact—a finding that is not and could not be challenged here—that forcing appellee Dr. Ragsdale to meet the requirements will cause his clinic to close. Similarly, enforcement would prevent appellee Margaret Moe from offering the abortion services necessary to meet demand to the extent such procedures become the primary function of her clinic. Such consequences in turn impose an undue burden on women who desire to exercise a fundamental constitutional right consistently recognized by this Court in *Roe* v. *Wade* and its progeny. That burden is undue as a matter of law because it is justified by no countervailing state interest in the health of pregnant women, as shown in Section IIA above. But that burden is also undue as a matter of fact, as the courts below held. For example, Dr. Ragsdale's clinic is the only provider of early pregnancy abortion services in all of Northwest Illinois, serving poor women at little or no cost. Closing his clinic, which enforcement of the Illinois regulations would

43 The enormous impact on abortion clinics, and hence the ability of women to exercise their constitutional rights effectively, is detailed in the results of the survey made for The Brief of the National Abortion Federation, *et al.*, as *Amicus Curiae* in Support of Appellees.

require, would mean effective denial of choice to a significant number of women. Even more significantly, however, regulations of this sort would, for many women, mean difficulty, and hence delay, in locating an affordable, easy provider of abortion services.

The net result of application of the Illinois regulatory scheme to abortion clinics would accordingly be a disservice to the health goals of the system, for delay itself is the principal cause of health risks in undergoing abortions. *See* Brief of the American College of Obstetricians and Gynecologists, *et al.*, as *Amicus Curiae* in Support of Appellees, and sources cited. Yet if the Illinois statute is deemed unconstitutional, there is no corresponding loss to the State's interest in the health of its citizens, for no demonstrated or contemplated health interest at all could be served by continuing to apply the stringent ASTC standards to facilities serving as abortions clinics.

There is thus no question that application of the ASTC scheme to abortion clinics should be judged by the standards that would be applied to a statute that directly regulates abortions only—even if those regulations may be plainly justified in all their other applications. Those standards require that the state show compelling reasons justifying the application of the statute to the constitutionally protected activity. *See, e.g.*, *Wisconsin* v. *Yoder*, 406 U.S. 205, 220 (1972); *Aptheker* v. *Secretary of State*, 378 U.S. 500, 508 (1964); *Sherbert* v. *Verner*, 374 U.S. 398, 403 (1963); *Shelton* v. *Tucker*, 364 U.S. 479, 488 (1960). Here there is no reason at all, except for hostility to the exercise of the protected right of choice, for the state to be interested in the application of these ASTC physical standards to abortion clinics. The preliminary injunction against such application is accordingly justified.

CONCLUSION

The decision of the Court of Appeals, upholding the preliminary injunction, should be affirmed, and the workable standards of *Roe* v. *Wade* should not be abandoned.

Respectfully submitted,

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BRIEF

88-790

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No. 88-709

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Supreme Court Of The United States
OCTOBER TERM 1989

BERNARD J. TURNOCK, M.D., et al.,

Appellants,

v.

RICHARD M. RAGSDALE, M.D., et al.,

Appellees.

ON APPEAL FROM THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF *AMICI CURIAE* OF THE COMMITTEES ON CIVIL RIGHTS, MEDICINE AND LAW, AND SEX AND LAW OF THE ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK AND OTHERS† ON BEHALF OF APPELLEES

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Queen's Bench of the San Francisco Bay Area

Women's Bar Association of Illinois

Women's Bar Association of the State of New York

Attorneys Action Council of Planned Parenthood Central and Northern Arizona

TABLE OF CONTENTS

Page

TABLE OF CASES ii

INTEREST OF *AMICI CURIAE* 1

INTRODUCTION AND SUMMARY OF ARGUMENT 4

I. THE ILLINOIS STATUTORY SCHEME IMPERMISSIBLY BURDENS A WOMAN'S FUNDAMENTAL RIGHT TO CHOOSE WHETHER TO TERMINATE HER PREGNANCY. 6

A. The Court of Appeals' Decision Applied Well-Established Constitutional Principles and Should be Affirmed. 6

B. The Fundamental Right of Women to Control Their Reproductive Destinies And Shape Their Lives Is And Should Remain An Integral Part of American Law and Life. 9

CONCLUSION 14

TABLE OF CASES

Page

Bellotti v. *Baird*, 443 U.S. 622 (1979) 9

Carey v. *Population Services*, 431 U.S. 678 (1977) 12

City of Akron v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983) 2,4–5,6–7,9

Colautti v. *Franklin*, 439 U.S. 379 (1979) 9

Eisenstadt v. *Baird*, 405 U.S. 438 (1972) 12

Griswold v. *Connecticut*, 381 U.S. 479 (1965) 2, 9, 10

Harris v. *McRae*, 448 U.S. 297 (1980) 9

Loving v. *Virginia*, 388 U.S. 1 (1967) 12

Maher v. *Roe*, 432 U.S. 464 (1977) 9

Moore v. *City of East Cleveland*, 431 U.S. 494 (1977) 12

Pierce v. *Society of Sisters*, 268 U.S. 510 (1925) 12

Planned Parenthood Ass'n v. *Ashcroft*, 462 U.S. 476 (1983) 9

Planned Parenthood of Central Missouri v. *Danforth*, 428 U.S. 52 (1976) 7, 9

Ragsdale v. *Turnock*, 841 F.2d 1358 (7th Cir. 1988), *juris. postponed*, 109 S. Ct. 3239 (1989) 7–8

Ragsdale v. Turnock, 625 F. Supp. 1212 (N.D. Ill. 1985), *aff'd in relevant part*, 841 F.2d 1358 (7th Cir. 1988), *juris. postponed*, 109 S. Ct. 3239 (1989) 7

Page

Roe v. *Wade*, 410 U.S. 113 (1973) ..... *passim*

Skinner v. *Oklahoma*, 316 U.S. 535 (1942) 9, 12

Texas v. *Johnson*, 109 S. Ct. 2533 (1989) 13

Thornburgh v. *American College of Obstetricians and Gynocologists*, 476 U.S. 747 (1986) 2, 4, 7–9, 11

Union Pacific Ry. Co. v. *Botsford*, 141 U.S. 250 (1891) 10

Webster v. *Reproductive Health Services*, 109 S. Ct. 3040 (1989) 5, 6, 9–10

West Virginia State Bd. of Educ. v. *Barnette*, 319 U.S. 624 (1943) 12

Zablocki v. *Redhail*, 434 U.S. 374 (1978) 12

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The Committees on Civil Rights, Medicine and Law, and Sex and Law of the Association of the Bar of the City of New York (the "Association") and others, with the consent of counsel to both parties, respectfully submit this brief in support of appellees.

INTEREST OF *AMICI CURIAE*

The Association of the Bar of the City of New York, chartered by the State of New York in 1871, is an organization of more than 18,000

attorneys. While most of its members practice in the New York metropolitan area, the Association has members in nearly every state and in more than forty foreign countries. Two important purposes of the Association, as set forth in its Constitution, are "promoting reforms in the Law" and "facilitating and improving the administration of justice." The Association accordingly has devoted itself to supporting and defending reforms in the law in cases of substantial public importance before the courts, including this Court.

The Association is committed to the principles of individual liberty and personal autonomy which this Court identified in its decisions in *Roe* v. *Wade*, 410 U.S. 113 (1973), and *Griswold* v. *Connecticut*, 381 U.S. 479 (1965). Once this Court declares, as it did in *Roe, City of Akron* v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983), and *Thornburgh* v. *American College of Obstetricians and Gynocologists*, 476 U.S. 747 (1986), that the individual rights of pregnant women foreclose certain state regulations which unreasonably obstruct a woman's exercise of her constitutionally protected freedom of reproductive choice, it violates our understanding of the fundamental concept of the rule of law for a state legislature to adopt new regulations even more intrusive than those held unconstitutional by this Court.

The Bar Association of San Francisco ("BASF") is a voluntary association of approximately 7,500 attorneys who reside or practice in the City and County of San Francisco, California. BASF's articles of incorporation include among its purposes furthering the public usefulness of the legal profession and increasing the profession's effectiveness in promoting the sound administration of justice. BASF has long supported women's rights of dignity, autonomy, and equality. BASF believes that the right of women to make their own reproductive choices is fundamental and must be constitutionally protected.

The Beverly Hills Bar Association ("BHBA") is a voluntary bar association formed on December 2, 1931 which currently has 3,000 members. The members of BHBA practice in and around the City of Beverly Hills, California. BHBA is committed to the protection of individual liberties and to promoting respect for the legal system. BHBA believes that a reversal of the landmark decision in *Roe* v. *Wade* would

impinge on individual liberties and would undermine public confidence in the legal system.

Lawyers Club of San Diego, Inc. ("Lawyers Club") is a California bar association founded in 1972, with current membership of almost 700 men and women, most of whom practice and reside in San Diego County, California. The purpose of the Lawyers Club is "to advance the status of women in the law, to support and improve the administration of justice and to promote equality of the sexes in our society." The rights of liberty and privacy are key to equality of the sexes. Any encroachment on the protections afforded by the Constitution and *Roe* v. *Wade* destroys the fundamental rights of women to control their pregnancies and their bodies. *Stare decisis* overrides revocation of these rights.

The Committee on Women's Rights of the New York County Lawyers' Association ("NYCLA") is a committee composed of women and men attorneys who concentrate their efforts on the elimination of discrimination against women. Founded in 1908, NYCLA is a Bar Association with a membership of approximately 11,000 attorneys, most of whom live or work in New York County. NYCLA's concerns include civil liberties, among other issues of social and legal significance. The Committee on Women's Rights, created in 1972, has prepared reports, commented on legislation, organized forums on issues of concern to the legal profession and participated as *amicus curiae* in litigation directed to the furtherance of women's and civil rights.

Queen's Bench is the largest bar association in the Northern California area established to promote the interests of women attorneys. Founded in 1921 it has almost 700 members. Queen's Bench is joining in this *amici curiae* brief because of its concern for maintaining a woman's fundamental right of choice to terminate a pregnancy that was established in *Roe* v. *Wade*.

The Women's Bar Association of Illinois ("WBAI") was founded in 1914 for the purpose of promoting and fostering the interests and welfare of women and women attorneys and to maintain the honor and dignity of the legal profession. WBAI's 1,000 members have long cam-

paigned for individual rights and liberties, including the right of women to make reproductive decisions free from governmental interference. WBAI has filed briefs *amicus curiae* before this Court on behalf of parties whose rights were in jeopardy, most recently in *Webster* v. *Reproductive Health Services*, as well as on behalf of petitioner in *Hishon* v. *King & Spalding*.

The Women's Bar Association of the State of New York ("WBASNY") is an organization of over 3,000 attorneys comprising fifteen chapters throughout the State. Founded in 1980, its stated purposes include the following: to cooperate with, aid and support organizations and causes which advance the status and progress of women in the society; to facilitate the administration of justice; and to cultivate the science of jurisprudence. The members of WBASNY support the principles enunciated in *Roe* v. *Wade*, including the recognition of a constitutionally guaranteed right to privacy.

The Attorneys Action Council of Planned Parenthood of Central and Northern Arizona is an organization of lawyers dedicated to the preservation of women's rights to the free exercise of family planning decisions, including the right to an abortion. The Council views any limitations on these rights as an invasion of women's right to privacy as protected by the United States Constitution.

INTRODUCTION AND SUMMARY OF ARGUMENT

This brief addresses the issue on appeal of particular concern to *amici*: whether the Illinois statutory scheme impermissibly burdens a woman's fundamental right to choose whether to terminate her pregnancy, incorporating the subsidiary issue of the continuing validity of the standard of review for laws regulating abortion established by this Court in *Roe* v. *Wade* and its progeny. *See, e.g., City of Akron* v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983); *Thornburgh* v. *American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986).

The court of appeals' decision was a correct application of this Court's approach to the types of regulation regarding early abortions

presented by the Illinois law. In *Akron*, the Court struck down regulations governing the facilities in which second trimester abortions would be performed on the ground that the regulations were not shown to be medically necessary to protect maternal health. Both the district court and court of appeals correctly applied the *Akron* standard in the instant case, properly relying on overwhelming evidence that the regulations were not medically necessary and would substantially burden the exercise of constitutionally protected rights by sharply restricting the availability of facilities for the performance of medically indicated abortions.

In striking down the challenged regulations, the lower courts properly applied the test which this Court has repeatedly articulated, requiring the state to demonstrate a compelling interest relating to maternal health to sustain its regulation when the regulation impacts on first and early second trimester abortions. The Court's decision in *Webster* v. *Reproductive Health Services*, 109 S. Ct. 3040 (1989), did not change that standard, which remains the appropriate standard for review. *Amici* submit that the Court should reject the State of Illinois' invitation to apply a rational relationship test or an intermediate standard of review. Brief for Appellants at 28. The requested ruling would be tantamount to overturning not only *Roe* v. *Wade*, but also this Court's recent decision in *Webster*. Illinois has presented no evidence of change in the law or deviation from safe early abortion procedures warranting the radical departure from the existing standard of review that they now propose.

The standard of review established in *Roe* and upheld in *Webster* is well suited to resolving the issues this case presents, which relate solely to regulations affecting safe, early abortions. That standard is particularly responsive to the Court's frequently articulated concerns about the status of women as equal participants in our society and is based on the Court's well-developed jurisprudence of privacy and individual autonomy.

I. THE ILLINOIS STATUTORY SCHEME IMPERMISSIBLY BURDENS A WOMAN'S FUNDAMENTAL RIGHT TO CHOOSE WHETHER TO TERMINATE HER PREGNANCY.

A. The Court of Appeals' Decision Applied Well-Established Constitutional Principles and Should be Affirmed.

The court of appeals' holding that Illinois' restrictive statutory and regulatory scheme violates the right of privacy and reproductive choice was required under Supreme Court precedent from *Roe to Webster*,[1] particularly the Court's decision in *City of Akron* v. *Akron Center for Reproductive Health*, 462 U.S. 416 (1983), and should be affirmed.

As the trial court found, based upon the voluminous factual record before it, Illinois' three-part regulatory scheme requires, in essence, that first and early second trimester abortions be performed in the equivalent of full-service mini-hospitals. The trial court's conclusion that the scheme therefore unconstitutionally burdens the fundamental right of a woman to choose to terminate her pregnancy follows necessarily from the Court's holding in *Akron*. There, the Court struck down a provision requiring that any abortion performed upon a pregnant

[1] As explained below at note 3 and accompanying text, the Court's decision in *Webster* did not alter the constitutional standard under which state regulation of abortion is reviewed. The only aspect of the decision that might even arguably be considered to have modified preexisting law is its treatment of the State's requirement of viability-testing. *See* 109 S. Ct. at 3054 (Rehnquist, C.J.). *But see id.* at 3060 (O'Connor, J.) ("I do not understand these viability testing requirements to conflict with any of the Court's past decisions concerning state regulation of abortion"). In any event, the provisions at issue in this case differ significantly from the viability-testing requirement at issue in *Webster*. The viability-testing provision of the Missouri Act affected only those abortions after 20 weeks where there was an arguably viable fetus and was "concerned with promoting the State's interest in potential human life rather than in maternal health." *Id.* at 3055. In contrast, the Illinois Ambulatory Surgical Treatment Center Act affects first and early second trimester abortions and, according to the State, was designed "to provide for the protection of the public health." Brief for Appellants at 5. Thus, *Webster* in no way changes the standard of review applied in the instant case.

woman during the second trimester of her pregnancy must be performed in a hospital. In so doing, the Court reaffirmed its long line of precedent placing the burden upon the state to show that the proposed restrictions on second trimester abortions are "reasonably designed to further" the state's interest in maternal health. 462 U.S. at 434; *see also Roe* v. *Wade*, 410 U.S. at 164.

For a state to interfere with first and early second trimester abortions, as the Illinois regulatory scheme purports to do, the state bears the even greater burden of showing not only that the regulation furthers important maternal health objectives, but that the effect on a woman's right of reproductive choice is *de minimis*. *Akron*, 462 U.S. at 430. Thus, regulations affecting first and early second trimester abortions have been upheld only when the state has established that their impact upon the exercise by a woman of her fundamental right was both insignificant and "justified by important state health objectives." *See, e.g., Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 79-81 (1976) (recordkeeping requirements upheld).

The Illinois regulatory scheme flouts that well-established and oft-affirmed precedent. For example, the elaborate and detailed physical plant requirements set forth in Title 77 of the Illinois Administrative Code, which mandate, *inter alia*, certain dimensions for examination rooms, procedure rooms, recovery rooms, corridors and doors, plainly lack even a minimally reasonable relationship to women's health, and the courts below so found. *See Ragsdale* v. *Turnock*, 841 F.2d 1358, 1373-74 (7th Cir. 1988), *juris. postponed*, 109 S. Ct. 3239 (1989). Indeed, as the trial court found and the court of appeals agreed, certain of the requirements could actually be "medically detrimental" to maternal health. *Id.* at 1368; *Ragsdale* v. *Turnock*, 625 F. Supp. 1212, 1230 n.23 (N.D. Ill. 1985), *aff'd in relevant part*, 841 F.2d 1358 (7th Cir. 1988), *juris. postponed*, 109 S. Ct. 3239 (1989). As the trial court further found, the regulations are so patently devoid of medical justification that they lack even a "rational basis." 625 F. Supp. at 1230.

The absence of medical justification for these hospital requirements that the State of Illinois seeks to impose, together with other elements of the Illinois scheme, belies appellants' contention that the

challenged regulations are "general" health regulations. For example, the State distinguishes between the physician who performs an occasional abortion in his or her office (whom the State does not purport to regulate), and one who performs abortions regularly (whom the State does seeks to regulate through its tripartite scheme). The evidence adduced at the hearing established, however, that "the physician who performs many abortions in general will have more expertise and therefore a better safety record." 841 F.2d at 1371. The court of appeals correctly concluded that the distinction drawn by the State "appear[s] to run contrary to sound health policy," and "to lack even a reasonable basis." *Id.*

The abortion-specific subparts of the Ambulatory Surgical Treatment Center Act ("ASTC Act") also run contrary to sound health policy as well as this Court's precedent. For instance, the Court has already considered and rejected a mandatory "counseling" requirement, almost identical to that provided for in the ASTC Act, mandating that women, regardless of the circumstances under which they seek an abortion, be advised of alternatives to abortions. *See Thornburgh*, 476 U.S. at 763 (mandatory counseling requirement may be "cruel as well as destructive of the physician-patient relationship" and "advances no legitimate state interest").

As found by the lower court, based on the testimony presented, the ASTC Act does not promote, but rather, undermines, the State's interest in women's health. It cannot be ignored "that the ASTC Act was enacted primarily with abortion clinics in mind and only applied to outpatient surgical clinics in an effort to save the statute from unconstitutionality."[2] *Ragsdale*, 841 F.2d at 1369. Yet, as this Court has cautioned repeatedly, "[t]he States are not free, under the guise of protecting maternal health," to interfere with a woman's exercise of her fundamental right of reproductive choice. *Thornburgh*, 476 U.S. at 759.

[2] The State of Illinois describes the challenged regulations as "abortion-neutral" despite the trial court's contrary finding of fact. However, appellant cites nothing in the record below to support a claim that that finding is clearly erroneous. There simply is no basis to set aside the lower court's factual findings.

In short, the challenged statute and regulations, in purporting to advance the State's interest in maternal health, are patently absurd. Since they plainly apply to both the first trimester, when the burden on the protected right must be insignificant, as well as the early second trimester pre-viability period, when they must be related to maternal health, they simply cannot survive scrutiny under the long line of authority discussed above. Accordingly, the court of appeals' decision should be affirmed.

B. The Fundamental Right of Women to Control Their Reproductive Destinies And Shape Their Lives Is And Should Remain An Integral Part of American Law and Life.

The court of appeals' decision correctly applied the constitutional standard repeatedly affirmed by this Court for the last sixteen years. *See, e.g., Thornburgh*, 476 U.S. 747 (1986); *Planned Parenthood Ass'n* v. *Ashcroft*, 462 U.S. 476 (1983); *City of Akron* v. *Akron Center for Reproductive Health*, 462 U.S. 416 (1983); *Bellotti* v. *Baird*, 443 U.S. 622 (1979); *Colautti* v. *Franklin*, 439 U.S. 379 (1979); *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52 (1976). The right of reproductive choice recognized in *Roe* and related cases, *e.g., Skinner* v. *Oklahoma*, 316 U.S. 535 (1942); *Griswold* v. *Connecticut*, 381 U.S. 479 (1965), has guaranteed women not only control over their bodies, but also the autonomy to evaluate their own life circumstances — economic, familial, and medical — and to exercise their own moral judgment about when and whether to bear children. Few, if any, decisions are more central to women's lives.

This Court has reaffirmed the fundamental nature of the right to reproductive choice, even in cases where it has curtailed the scope of that right. *See, e.g., Harris* v. *McRae*, 448 U.S. 297, 312 (1980) ("'liberty' protected by the Due Process Clause of the Fourteenth Amendment includes not only the freedoms explicitly mentioned in the Bill of Rights, but also a freedom of personal choice in certain matters of marriage and family life"); *Maher* v. *Roe*, 432 U.S. 464, 471 (1977) (noting "fundamental right" recognized in *Roe*). In *Webster* v. *Reproductive Health Services*, 109 S. Ct. 3040 (1989), while upholding regulations

concerning certain abortion-related medical procedures, the Court did not alter the constitutional standard under which state regulation of abortion is reviewed.[3] A majority of the justices reaffirmed the strict standard of review established in *Roe* and its progeny. *Id.* at 3062–64 (O'Connor, J., concurring in part and concurring in the judgment); *id.* at 3067 (Blackmun, J., concurring in part and dissenting in part); *id.* at 3079 (Stevens, J., concurring in part and dissenting in part). As Justice O'Connor stated:

> The Court today has accepted the State's every interpretation of its abortion statute and has upheld, *under our existing precedents*, every provision of that statute which is properly before us.

Id. at 3061 (emphasis added.)

The continuing recognition of a woman's fundamental right of reproductive choice is the product of a sophisticated body of doctrine generated by a quarter century of decisions stemming from this Court's ruling in *Griswold* v. *Connecticut*, and this Court's earlier jurisprudence in the privacy arena, *see Roe* v. *Wade*, 410 U.S. at 152 (citing *Union Pacific Ry. Co.* v. *Botsford*, 141 U.S. 250, 251 (1891)).

The right of reproductive choice has deep roots in our nation's historical approach to abortion. Abortion was a lawful option for

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3 Chief Justice Rehnquist, speaking for the plurality, explicitly declined to overrule the Court's decision in *Roe v. Wade*.

> The facts of the present case, however, differ from those at issue in *Roe*. Here, Missouri has determined that viability is the point at which its interest in potential human life must be safeguarded. In *Roe*, on the other hand, the Texas statute criminalized the performance of *all* abortions, except when the mother's life was at stake. *This case therefore affords us no occasion to revisit the holding of Roe*, which was that the Texas statute unconstitutionally infringed the right to an abortion derived from the Due Process Clause, and *we leave it undisturbed.*"

109 S. Ct. at 3058 (citations omitted) (emphasis added in part).

women in this country well into the late nineteenth century. Medical justifications for the subsequent criminalization of abortion were absent by the time *Roe* was decided. *Roe* v. *Wade*, 410 U.S. at 129–147. The organized medical profession, which was instrumental in the passage of restrictive late nineteenth century statutes, as a health measure, now agrees that every individual has a fundamental right to make an individual medical treatment decision, such as whether to terminate a pregnancy, free of state interference absent a compelling justification for the restrictions imposed. *See* Brief of the American Medical Association, *et al.*, as *Amicus Curiae*, in *Webster* v. *Reproductive Health Services*, No. 88–605, at 1.

The legal basis for the fundamental right to reproductive choice recognized in *Roe* is sound and consistent with our constitutional system in which "limitations on government, administered by the judiciary, are a crucial characteristic . . . ." Henkin, *Privacy and Autonomy*, 74 Colum. L. Rev. 1410, 1427 (1974). *See* Rubenfeld, *The Right To Privacy*, 102 Harv. L. Rev. 737 (1989) (right to privacy is fundamental freedom which protects against substantial or rigid direction of individual lives by the state). The Court has a long tradition of recognizing unenumerated rights in the area of personal liberty. Justice White, joined by Chief Justice Rehnquist, has observed:

> As [our] prior cases clearly show . . ., this Court does not subscribe to the simplistic view that constitutional interpretation can possibly be limited to the "plain meaning" of the Constitution's text or to the subjective intention of the Framers. The Constitution is not a deed setting forth the precise metes and bounds of its subject matter; rather, it is a document announcing fundamental principles in value-laden terms that leave ample scope for the exercise of normative judgment by those charged with interpreting and applying it.

Thornburgh, 476 U.S. at 789.

The Ninth Amendment, which provides that "[t]he enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people," is the starting point for protecting the fundamental right to reproductive choice. In addition to the

tradition of identifying fundamental rights not found in the text of the Constitution, *Roe* drew on the Court's related tradition of identifying unenumerated rights that protect individuals from government interference in family autonomy and decision making. Unenumerated but fundamental rights the Court has recognized in this area include the right to procreate, *Skinner* v. *Oklahoma*, 316 U.S. 535 (1942); the right to educate one's children in conformity with minimum state standards, *Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925); the right to marry a partner of one's choice, *Zablocki* v. *Redhail*, 434 U.S. 374 (1978); *Loving* v. *Virginia*, 388 U.S. 1 (1967); and the right to habitate with extended family, *Moore* v. *City of East Cleveland*, 431 U.S. 494 (1977).

Beginning with *Griswold* v. *Connecticut*, 381 U.S. 479 (1965), the Court's recognition of fundamental family rights has been extended to encompass decisions about contraceptives and the termination of pregnancy. *E.g.*, *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972); *Carey* v. *Population Services*, 431 U.S. 678 (1977). In *Roe* and its progeny, the Court elaborated upon these rights. In *Thornburgh*, the Court referred to this tradition, explaining, "Our cases have long recognized that the Constitution embodies a promise that a certain private sphere of individual liberty will be kept largely beyond the reach of government." 476 U.S. at 772.

The fundamental nature of a woman's right to reproductive choice is underscored by the relation between reproductive rights and women's status in society. As Judge Ruth Bader Ginsburg has stated: "Inevitably, the shape of the law on . . . reproductive autonomy indicates and influences the opportunity women will have to participate as men's full partners in the nation's social, political and economic life." Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe* v. *Wade*, 63 N.C.L. Rev. 375 (1985).

"The very purpose of a Bill of Rights was to withdraw certain subjects from the vicissitudes of political controversy . . . . [F]undamental rights may not be submitted to vote; they depend on the outcome of no elections." *West Virginia State Bd. of Educ.* v. *Barnette*, 319 U.S. 624, 638 (1943). The specter of fifty different systems regulating reproductive choice cannot be harmonized with a constitutionally protected

fundamental right. Nor can the protection of liberty, privacy, autonomy, and equality be a function of majority rule or a product of governmental coercion.

Justice Kennedy recently wrote of the Court's duty in controversial cases, in words that apply here with equal force:

> The hard fact is that sometimes we must make decisions we do not like. We make them because they are right, right in the sense that the law and the Constitution, as we see them, compel the result.

Texas v. *Johnson*, 109 S. Ct. 2533, 2548 (1989) (Kennedy, J., concurring). A foundation of our constitutional jurisprudence is the fundamental personal right to liberty, privacy, autonomy and equality which must be safeguarded against undue governmental intrusion. We urge that the Court honor these values by reaffirming the right of a woman, in consultation with her doctor, to decide whether to terminate her pregnancy, and affirming the vindication of that right by the courts below.

CONCLUSION

For the foregoing reasons, *amici* urge this Court to uphold the standard of review established in *Roe* v. *Wade* and to affirm the decision of the court of appeals.

Dated: October 9, 1989

Respectfully submitted,

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BRIEF

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No. 88-790

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, *et al.*,
Appellants,

v.

RICHARD M. RAGSDALE, M.D., *et al.*,
Appellees.

On Appeal from the United States Court of Appeals for the Seventh Circuit

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BRIEF OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, AMERICAN MEDICAL WOMEN'S ASSOCIATION, AMERICAN NURSES' ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION AND NURSES' ASSOCIATION OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS AS *AMICI CURIAE* IN SUPPORT OF APPELLEES

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QUESTIONS PRESENTED

Amici curiae will address the following questions:

1. Whether state laws that flatly prohibit physicians from performing first and early second trimester abortions in their offices unconstitutionally infringe a woman's fundamental right in consultation with her physician to terminate her pregnancy, and deny physicians seeking to perform abortions the equal protection of the laws.

2. Whether a state law and regulations that require any medical facility devoted primarily to surgical procedures to be built to hospital-like specifications is unconstitutional as applied to facilities devoted primarily to performing abortions.

3. Whether a state regulation that prohibits physicians and their paid staff from counseling their patients about abortions unconstitutionally infringes a woman's right in consultation with a physician to decide whether to terminate her pregnancy.

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
TABLE OF AUTHORITIES	v
INTEREST OF *AMICI CURIAE*	1
MEDICAL BACKGROUND	3
I. Prevalence And Safety Of Induced Abortion	3
II. Clinical Setting And Demographic Context	8
SUMMARY OF ARGUMENT	11
ARGUMENT	13
I. ILLINOIS' STATUTORY REQUIREMENTS THAT ABORTIONS BE PERFORMED EXCLUSIVELY IN HOSPITALS OR AMBULATORY SURGICAL TREATMENT CENTERS UNCONSTITUTIONALLY BURDEN A WOMAN'S RIGHT TO TERMINATE HER PREGNANCY	14
A. Section 16(1) Of The MPA And The Second Clause Of Paragraph 157-8.3(A) Of The ASTCA Preclude Physicians From Performing Abortions In Their Offices And Are Therefore Unconstitutional	15
B. Because It Precludes Physicians From Performing Abortions In Offices Or Clinics "Primarily Devoted" To Abortions, The First Clause Of Paragraph 157-8.3(A) Is Unconstitutional As Applied To First And Early Second Trimester Abortions	19
1. Nature of the Burden	21
2. Relation to the State's Interest	27

TABLE OF CONTENTS—Continued

Page

II. ILLINOIS' ABORTION COUNSELING REGULATION, SECTION 205.730(b)(2)(D), WHICH REQUIRES THAT ABORTION COUNSELORS NOT HAVE A FINANCIAL INTEREST IN THE PATIENT'S DECISION, UNCONSTITUTIONALLY PRECLUDES PHYSICIANS AND PAID STAFF FROM COUNSELING PATIENTS 28

CONCLUSION 30

TABLE OF AUTHORITIES

Cases: Page

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City of Akron v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983) ..... *passim*
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Connecticut v. *Menillo*, 423 U.S. 9 (1975) 19
Doe v. *Bolton*, 410 U.S. 179 (1973) 16, 18
Eisenstadt v. *Baird*, 405 U.S. 438 (1972) 13
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TABLE OF AUTHORITIES—Continued

	Page
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77 Ill. Admin. Code, Chapter 1, § 205, Subchapter b, Subpart I, 205.730(b) (2) (D)	13, 28, 29, 30
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	Page
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Page

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Page

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On Appeal from the United States Court of Appeals for the Seventh Circuit

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BRIEF OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, AMERICAN MEDICAL WOMEN'S ASSOCIATION, AMERICAN NURSES' ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION AND NURSES' ASSOCIATION OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS AS *AMICI CURIAE* IN SUPPORT OF APPELLEES

INTEREST OF *AMICI CURIAE*

Amici curiae are six major organizations of health care professionals. *Amici* share an abiding dedication to promoting the public welfare through the maintenance of the highest professional standards and the provision of quality health care. *Amici*'s interest is not in debating the philosophical, ethical, moral or religious issues surrounding abortion. Indeed, their members hold divergent views on some of these issues. Their members agree,

however, that every individual has a fundamental right to make individual medical treatment decisions free of unwarranted state interference.

Amicus American College of Obstetricians and Gynecologists ("ACOG") is a private, voluntary, nonprofit organization of physicians who specialize in obstetric and gynecologic care. ACOG is the leading group of professionals providing health care to women; its 28,000 members represent approximately 90 percent of all obstetricians and gynecologists practicing in the United States.

Amicus American Academy of Child and Adolescent Psychiatry ("AACAP") is a national professional organization of over 4,200 child and adolescent psychiatrists, who engage in research, prevention, diagnosis and treatment of developmental and psychiatric disorders in children, adolescents and families.

Amicus American Medical Women's Association, Inc. ("AMWA") is a nonprofit organization of 12,000 women physicians and medical students. One of AMWA's primary missions is to promote quality health care for women. AMWA strongly opposes laws which adversely affect the health of women, or impose constraints on the right of the pregnant patient, in consultation with her physician, to make a personal and medically informed decision whether or not to continue a pregnancy.

Amicus American Nurses' Association ("ANA") is an association of registered nurses that is dedicated to the advancement of the goals and interests of registered nurses and of the nursing profession generally. The ANA is comprised of 53 constituent member organizations, which represent the nation's two million registered nurses, the largest group of health care providers in this country. ANA has historically worked for access to health care for all Americans.

Amicus American Psychiatric Association ("APA") is the nation's largest professional association specializing in psychiatry, with a membership exceeding 30,000 physicians. APA's purposes include promoting the welfare of patients who require psychiatric services.

Amicus Nurses' Association of the American College of Obstetricians and Gynecologists ("NAACOG") is a 23,000 member professional organization for nurses who provide health care for women and infants. NAACOG's purpose is to establish relevant nursing standards and to assist its members in supplying the highest quality nursing care to their clients.

In *amici*'s view, the Illinois Ambulatory Surgical Treatment Center Act ("ASTCA"), its implementing regulations and provisions in other Illinois statutes at issue in this case unduly interfere with the woman's right to seek and obtain medical care and arbitrarily prevent her physician and other health care providers from providing quality medical treatment.[1] *Amici* believe that the outcome of this case will directly affect the professional services their members provide and the health of the patients whom they serve. Accordingly, *amici* wish to present their views concerning the important issues raised in this appeal.[2]

MEDICAL BACKGROUND

I. Prevalence And Safety Of Induced Abortion

Induced abortion is one of the most common and safest surgical procedures performed today.[3] Between

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[1] By focusing on the constitutionality of some, but not all, of the provisions at issue in this case, *amici* do not intend to imply that they endorse or condone the remainder of the Illinois scheme. *Amici* intend to focus only on those specific statutes that pose the greatest burden on a woman's fundamental right to choose to terminate her pregnancy and that interfere most with the practice of medicine and the provision of health care.

[2] Pursuant to Rule 36 of the Rules of this Court, the parties have consented to the filing of this brief. The parties' letters of consent have been filed with the Clerk of the Court.

[3] Darney, Landy, MacPherson & Sweet, *Abortion Training in U.S. Obstetrics and Gynecology Residency Programs*, 19 Fam. Plann. Persp. 158, 161 (1987); Binkin, *Trends in Induced Legal*

1981 and 1985, the most recent year for which statistics are available, the number of annual abortions was roughly constant, at approximately 1.59 million abortions per year, for a rate of about one abortion for every 40 women aged 15-44.[4] More than one in five American women aged 15-44 have had an abortion, and if current rates continue, almost half (46%) of all American women will have had an abortion by the time they are 45.[5]

Since 1973 when this Court observed that maternal mortality from abortion was lower than maternal mortality from childbirth, *Roe* v. *Wade*, 410 U.S. 113, 149, 163 (1973), it has become clear that abortion is far safer than childbirth. The mortality rate for abortion has declined significantly since 1973, and at a faster rate than the mortality rate for childbirth.[6] While in 1972 the risk of a woman dying from abortion procedures was 4.1 per 100,000 procedures, by 1981 this risk had decreased to .5 per 100,000 abortions, or roughly one death for every 200,000 abortions.[7]

Abortion Morbidity & Mo.tality, 13 Clin. Obstet. Gynec. 83, 83 (1986); Grimes, *Surgical Management of Abortion*, in Te Linde's Operative Gynecology 513, 538 (R. Mattingly & J. Thompson, eds. 1985); W. Hern, Abortion Practice 23 (1984).

[4] Henshaw, Forrest & Van Vort, *Abortion Services in the United States, 1984 and 1985*, 19 Fam. Plann. Persp. 63, 64 (1987). In addition, approximately one in four pregnancies ended in induced abortion. *Id. See also* Grimes, *Provision of Abortion Services in the United States*, in Abortion: Medical Progress and Social Implications 26, 27 (1985).

[5] Forrest, *Unintended Pregnancy Among American Women*, 19 Fam. Plann. Persp. 76, 76-77 (1987).

[6] Grimes, *Surgical Management* at 536.

[7] Binkin, *Trends in Induced Legal Abortion* at 85. *See also* Lebolt, Grimes & Cates, *Mortality From Abortion and Childbirth: Are the Populations Comparable?*, 248 J.A.M.A. 188, 189 (1982); Grimes, *Surgical Management* at 537.

By contrast, in 1981, the risk of a mother dying from childbirth was 8.5 per 100,000 live births,[8] more than ten times the risk of abortion generally, and more than 20 times the risk of a first trimester abortion.[9] Childbirth also carries a much higher risk of complication than does abortion.[10] By comparison to other common surgical procedures, a tonsillectomy is twice as likely to cause the death of a patient as is an abortion, and an appendec-

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[8] U.S. Dep't of Health and Human Services, 2A *Vital Statistics of the United States 1981* 64.

[9] LeBolt, *Mortality From Abortion* at 191. The reported mortality figures may understate the relative safety of abortion compared to childbirth. According to a number of studies, mortality statistics published by the federal government underestimate the number of maternal deaths from childbirth by as much as 37%-50%. Cates, Smith, Rochat & Grimes, *Mortality from Abortion and Childbirth: Are the Statistics Biased?*, 248 J.A.M.A. 192, 194; Rochat, Koonin, Atrash & Jewett, *Maternal Mortality in the United States: Report from the Maternal Mortality Collaborative*, 72 Obstet. Gynec. 91, 92 (1988). The data on abortion mortality, on the other hand, are highly accurate. This is because efforts to detect maternal mortality from abortion have been very thorough. Cates, *Mortality from Abortion and Childbirth*.

[10] *Compare* Placek & Taffel, *Recent Patterns in Cesarean Delivery in the United States*, 15 Obstet. Gynec. Clin. N.A. 607, 612, 615 (1988) (63% of women suffer some adverse health effect during pregnancy) *with* Cates & Grimes, *Morbidity and Mortality of Abortion in the United States*, in Abortion and Sterilization: Medical and Social Aspects 155, 159 (J. Hodgson, ed. 1981) (12% of abortions result in some medical complication) *and* U.S. Dep't of Health and Human Services, Public Health Service, Centers for Disease Control, *Induced Terminations of Pregnancy: Reporting States, 1985 and 1986*, 37 Monthly Vital Statistics Report 7 (1989) (3.3 complications per 1,000 abortions regardless of gestational age.) *See also* Hakim-Elahi & Tovell, *Complications of First-Trimester Abortion: A Report of 170,000 Cases*, in The American College of Obstetricians and Gynecologists, Abstracts of Current Clinical and Basic Investigation 20, 20 (1989) (study of 170,000 abortions performed within 14 weeks revealed no deaths and a complication rate of less than one percent); Grimes, *Surgical Management* at 533 (fewer than 2 abortions per 1,000 performed by suction curettage result in serious complications).

tomy or laparoscopy is 100 times more likely to cause death.[11]

There are several important factors that contribute to the safety of induced abortion, and that explain the increasing safety with which it has been performed in recent years. First, and most important, is the distinct trend toward early abortions. Between 1972 and 1981, the percentage of abortions performed at eight weeks gestation or earlier increased from 34% to 51%; similarly, the percentage of second trimester abortion dropped from 18% to 10%.[12] This trend is important because "[w]ithin the first 12 weeks, the main risk to a woman who wants an abortion results from delay." [13]

The second factor contributing to the decrease in risk is the widespread use of safer abortion techniques. There are two broad categories of abortion methods: instillation and dilation and evacuation (D & E). Grimes, *Surgical Management* at 525.[14] The safest method of abortion in the first trimester is suction curettage, a type of D & E. *Id.* In this method, no incision is necessary, and only local anesthesia is required. *Id.* at 526-27. The entire procedure, including anesthesia, takes no more than 10 to 12 minutes. J.A. 76. The use of suction curettage increased from 65% of abortions in 1972 to 90% of abortions in 1981, while the use of instillation techniques concomitantly decreased, from 10% in 1972

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[11] W. Hern, Abortion Practice at 23-24; *cf.* Phillips, *Complications in Laparoscopy*, 15 Int'l. J. Gynaec. Obstet. 157 (1977).

[12] Binkin, *Trends in Induced Legal Abortion* at 88.

[13] Cates, Schulz, Grimes & Tyler, *The Effect of Delay and Method Choice On the Risk of Abortion Morbidity*, 9 Fam. Plann. Persp. 266, 267 (1977); *see* Grimes, *Surgical Management* at 537.

[14] Dilation and evacuation methods involve two steps: (a) widening of the cervix until it is large enough to permit insertion of instruments into the uterus for removal of fetal tissue, and (b) removal of the fetal tissue. Instillation involves the infusion in the amniotic cavity of labor-inducing drugs or agents, such as prostaglandin. *See* W. Hern, Abortion Practice at 124-26.

to 3% in 1981.[15] For second trimester abortions, D & E methods have become widely recognized as safer than instillation methods.[16] One study has estimated that the increased use of D & E techniques yielded a 90% decrease in serious complications from second trimester abortions.[17]

A third factor in determining the safety of an abortion procedure, perhaps most important in any individual instance, is the skill of the physician. Grimes, *Surgical Management* at 531. The risk of complications increases significantly when the physician performing the operation lacks adequate training and experience.[18]

As a result of the trend to early abortions and improvements in technique and operator skill, a high percentage of maternal deaths from abortion result not from the abortion procedure itself but instead from the use of general anesthesia.[19] For first trimester abortions, use

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[15] Grimes, *Abortion Services in the United States* at 30.

[16] Stubblefield, *Surgical Techniques of Uterine Evacuation in First- and Second-Trimester Abortion*, 13 Clin. Obstet. Gynec. 53, 63-67 (1986); *see* Grimes, *The Safety of Midtrimester Abortion*, Medical Digest 1 (1987). Other methods of dilation and evacuation, including mechanical or sharp curettage, are sometimes used in the first trimester, but are not medically preferred. Grimes, *Abortion Services in the United States* at 30.

[17] Cates, Schulz, Grimes, Horowitz, Lyon, Kravitz & Frisch, *Dilation & Evacuation Procedures and Second Trimester Abortions: The Role of Physician Skill and Hospital Setting*, 248 J.A.M.A. 559, 561 (1982).

[18] Binkin, *Trends in Induced Legal Abortion* at 87; Grimes & Schulz, *Morbidity and Mortality from Second-Trimester Abortions*, 30 J. Reprod. Med. 505, 506 (1985); Grimes, Schulz, & Cates, *Prevention of Uterine Perforation During Curettage Abortion*, 251 J.A.M.A. 2108, 2111 (1984); W. Hern, Abortion Practice at 103-04.

[19] Atrash, Cheek & Hogue, *Legal Abortion Mortality and General Anesthesia*, 158 Am. J. Obstet. Gynec. 420, 421 (1988). During the period 1974-1977 "complications of anesthesia or analgesia were the most frequent cause of death," Grimes, Cates & Selik, *Abortion Facilities and the Risk of Death*, 13 Fam. Plann. Persp. 30, 32 (1981), and from 1977 to 1981 one in five abortion deaths were

of general anesthesia is associated with a twofold to fourfold increase in the risk of death.[20] Use of general anesthesia is also associated with an increase in serious complications arising from second trimester abortions.[21]

II. Clinical Setting And Demographic Context

Abortions may be safely perfomed in any of four settings: a doctor's office, an outpatient clinic, a freestanding ambulatory surgical facility or a hospital. American College of Obstetricians and Gynecologists, *Standards for Obstetric-Gynecologic Services* 65-74 (7th ed. 1989) ("ACOG Standards").[22] For uncomplicated abortions performed up to 14 weeks, which represent over 90% of all abortions performed in this country, a physician's office or clinic is the *most appropriate* setting. *Id.* As discussed above, suction curettage, a low-risk procedure involving no incision and requiring only local anesthesia, is akin to numerous other minor surgical procedures that are routinely and efficiently performed

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directly attributable to general anesthesia, making general anesthesia one of two leading causes of abortion death. Binkin, *Trends in Induced Legal Abortion* at 90.

[20] Peterson, Grimes, Cates & Rubin, *Comparative Risk of Death from Induced Abortion at <12 Weeks' Gestation Performed With Local Versus General Anesthesia*, 141 Am. J. Obstet. Gynec. 763 (1981).

[21] Mackay, Schulz & Grimes, *Safety of Local Versus General Anesthesia for Second-Trimester Dilation and Evacuation Abortion*, 66 Obstet. Gynec. 661 (1985). An alert patient is able to report or react to symptoms, such as the surgeon pushing too hard with an instrument, that may lead to complications such as cervical injury or perforation of the uterus. Stubblefield, *Surgical Techniques of Uterine Evacuation* at 65; W. Hern, Abortion Practice at 119-20. General anesthesia also increases bleeding associated with abortion, depresses the gag reflex creating the possibility of aspiration of vomitus and increases the risk of cardiopulmonary failure. *Id.*

[22] During the preliminary injunction hearing below, the parties referred to the Sixth Edition of the ACOG Standards, published in 1985. There is no material difference in the discussions of clinical settings for abortion between the Sixth and Seventh Editions. *Compare* Seventh Edition at 65-74 *with* Sixth Edition at 60-70.

with least emotional trauma for patients in an office or clinic.[23] For later second trimester or instillation abortions, and for abortions for patients at high risk or with complicating conditions, a hospital or freestanding ambulatory surgical facility is often preferable. See ACOG Standards at 68-69; Henshaw, Forrest & Van Vort, *Abortion Services in the United States, 1984 and 1985*, 19 Fam. Plann. Persp. 63, 67 (1987). Such facilities are appropriate if the surgery must be performed with general anesthesia, or if there is a significant likelihood of complications requiring a hospital's support services.[24]

At the time this Court decided *Roe* v. *Wade*, most abortions were performed in hospitals. Henshaw, *Abortion Services* at 67. Since then, "there has been a pronounced movement toward nonhospital facilities." *Id.* By 1985, only 13% of abortions took place in hospitals. *Id.* The majority of abortions—60%—are now performed in outpatient clinics, while 23% of abortions are performed in other clinics (including surgicenters not primarily devoted to abortions) and 4% in doctors' offices.[25] *Id.* at 68.

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[23] *Id.*; *see* P. Martin, Ambulatory Gynecologic Surgery 99-101 (1979); J.A. 75.

[24] The State misleads the Court when it implies that ACOG's standards endorse the use of ASTC's for first-trimester abortion services. *See* J.S. 12; Brief for Appellants at 42. The passage from which the State selectively quotes makes plain ACOG's position that abortions may be safely performed in a physician's office. ACOG Standards at 68 states: "Ambulatory care facilities should meet the same standards of care for abortion services as for other surgical procedures. *Physicians who perform abortions in their offices* should provide for prompt emergency treatment or hospitalization of patients in the event that a complication occurs. *Clinics* and freestanding ambulatory care facilities should have a mechanism for the transfer of patients requiring emergency treatment to a nearby hospital." (Emphasis added).

[25] The figures for physicians' offices and abortion clinics are to some extent interdependent; an abortion clinic is defined to include those physicians' offices in which more than 400 abortions are performed annually or more than 50% of patient visits are for abortions. Henshaw, *Abortion Services* at 68.

The growth in outpatient clinics that perform abortions has resulted in part from the fact that a hospital abortion costs on average more than three times as much as a clinic abortion. *Id.* at 67. It also reflects the fact that abortions performed in clinics are at least as safe as those performed in hospitals or free-standing surgical centers. Grimes, Cates, & Tyler, *Comparative Risk of Death From Legally Induced Abortion In Hospitals and Nonhospital Facilities*, 51 Obstet. Gynec. 323 (1978). The factors chiefly responsible for determining the safety of induced abortion—the time of gestation, the procedure used and the skill of the physician—all operate independent of the setting in which the operation is performed. In this respect, first and early second trimester abortions are no different than other minor surgical procedures, such as dilation and curettage ("D & C"),[26] aspiration of a cyst or removal of skin lesions.

The decline in the number of abortions performed in hospitals has been acompanied by a steady decline in the number of hospitals that offer abortion services. Only 21% of the nation's short-term general hospitals performed any abortions in 1985, a decrease of 15 percent since 1982; among those that did, 43% of them performed fewer than 30 abortions during that year. Henshaw, *Abortion Services* at 68. Such a pattern reflects, in part, the use of hospitals chiefly for complicated abortions and high-risk patients. *Id.* at 67.

The hospitals, ambulatory surgical centers, clinics and physicians' offices that provide abortions are heavily concentrated in urban areas. Eighty-two percent of all U.S. counties, including half of all metropolitan counties and 91% of non-metropolitan counties, lacked any abortion provider in 1985. *Id.* at 65. Furthermore, 65% of metropolitan counties and 99% of non-metropolitan counties lacked a large-scale abortion provider (one performing

[26] D & C is a diagnostic procedure used, *inter alia*, to examine uterine tissue; it is analogous to the D & E abortion procedures. *See* J.A. 80, 190; P. Martin, Ambulatory Gynecologic Surgery at 171-79; ACOG Standards at 66.

400 or more abortions a year). *Id.* This uneven distribution has a significant impact on access to abortion services. Nearly one-third (30%) of all women in America aged 15-44 live in a county lacking such a provider, and these women obtain far fewer abortions on average than other women. *Id.* Although regional differences in abortion demand in theory could explain this disparity, "there is abundant evidence that the local availability of abortion services has an important effect on the utilization rate." *Id.* at 66.[27]

SUMMARY OF ARGUMENT

In *Roe* v. *Wade*, 410 U.S. 113 (1973), this Court held that a woman has a constitutional right to terminate an unwanted pregnancy free from unwarranted interference by state law. This constitutional protection flows from the liberty component of the Due Process Clause of the Fourteenth Amendment, which guarantees individuals the liberty to make certain important and inherently personal choices. Last term, in *Webster* v. *Reproductive Health Services*, 109 S. Ct. 3040 (1989), a majority of the Court left "undisturbed" *Roe*'s core holding that the right to an abortion is constitutionally protected. *Id.* at 3058.

This appeal involves a challenge to Section 16(1) of the Illinois Medical Practice Act, which precludes physicians from performing first trimester abortions in their offices, and to the application of Illinois' ASTCA and by extension its Health Facilities Planning Act ("HFPA")

[27] *See* Shelton, Brann & Schulz, *Abortion Utilization: Does Travel Distance Matter?*, 8 Fam. Plann. Persp. 260, 262 (1976) (comprehensive study of abortion patterns in Georgia shows that "the farther a woman has to travel to obtain an abortion, the less likely she is to obtain one"); Tatalovich & Daynes, *The Geographic Distribution of U.S. Hospitals With Abortion Facilities*, 21 Fam. Plann. Persp. 81, 81 (1989) (local availability of abortion procedures affects use); Henshaw, *Abortion Services* at 65, 66 (national data support conclusion that "scarcity of abortion providers" and "need to travel long distances" deter some women from obtaining abortions).

to abortion clinics. Both courts below enjoined the application of these statutes to the provision of abortion services, and in so holding, both courts relied on the trimester analysis as announced in *Roe* and employed in *City of Akron* v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983). This Court need not employ the trimester analysis of *City of Akron*, however, to affirm the decision of the court of appeals. As a majority of the Court indicated in *Webster*, when legislation significantly burdens the right to obtain an abortion, the Court must apply heightened scrutiny in determining the degree to which that statute serves legitimate state interests.

I.

The record in this case amply demonstrates that application of the challenged statutes to all abortions will impose an unprecedented and extraordinary burden on the right of women in Illinois to seek and obtain an abortion. The effect of these statutes is to reduce substantially the availability of abortion providers in nonmetropolitan areas, thereby (1) denying some women any access to an abortion, and (2) placing many others at substantially greater risk of suffering major complications or even death by delaying access to abortion providers. Because the statutes involved apply statewide and to all abortions, they impose a far greater burden than other statutes previously invalidated by this Court. *Cf. City of Akron*, 462 U.S. at 431-39. And unlike other statutes upheld by this Court because they involved no more than government refusal to subsidize abortion services, *cf. Webster*, 109 S. Ct. at 3052-53, the statutes at issue here constitute affirmative state interference with the private provision of abortion services.

The Illinois statutes do not further the State's interest in any rational way. The evidence is abundant and irrefutable that first-trimester abortions, like many other minor surgical procedures, may be performed at least as safely in physicians' offices and clinics as in ASTC's or hospitals. By eliminating physicians' offices and clinics as facilities available to provide abortions and thereby increasing delay in obtaining abortions, Illinois' statutes operate not to protect but to threaten maternal health. This Court should therefore hold them unconstitutional.

II

In addition, one particular provision of Illinois' regulations implementing the ASTCA, 77 Ill. Admin. Code, Chapter 1, § 205, Subchapter b, Subpart I, 205.730(b)(2)(D), cannot withstand even the most deferential review. By preventing physicians and their paid staff from counseling abortion patients, this provision intrudes dramatically and senselessly into the physician-patient relationship and is therefore unconstitutional. Compare *Planned Parenthood* v. *Danforth*, 428 U.S. 52, 68 (1976).

ARGUMENT

This Court has long recognized that the individual has a fundamental right, derived from the concept of liberty in the Due Process Clause, to have "independence in making certain kinds of important decisions." *Whalen* v. *Roe*, 429 U.S. 589, 599-600 (1977). At the core of this right are decisions concerning procreation and marriage; unwarranted state interference with such inherently personal and private decisions is antithetical to basic concepts of individual liberty in the free society protected by our Constitution. See *Griswold* v. *Connecticut*, 381 U.S. 479 (1965); *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972); *Loving* v. *Virginia*, 388 U.S. 1 (1967); see also *Skinner* v. *Oklahoma*, 316 U.S. 535, 541 (1942).

In *Roe* v. *Wade*, 410 U.S. 113 (1973), this Court held that this fundamental right embraces a woman's decision whether and how to terminate her pregnancy. In subsequent cases, notably *City of Akron* v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983), the Court refined an analytic framework for protecting the right in *Roe*. Although a majority of this Court has come to view this trimester framework as "problematic," *Webster* v. *Reproductive Health Services*, 109 S. Ct. at 3063 (O'Connor, J., concurring in part and concurring

in the judgment), the Court in *Webster* left "undisturbed" its essential conclusion in *Roe* that the Texas statute challenged there "unconstitutionally infringed the right to an abortion derived from the Due Process Clause." 109 S. Ct. at 3058.

In this case, the State expressly declines to challenge the validity of *Roe*'s conclusion that a woman has such a right, but argues nevertheless that state legislation affecting this right should be subject only to rational-relationship review. While such review is appropriate for "legislative Acts adjusting the burdens and benefits of economic life," *Pension Benefit Guaranty Corp.* v. *R.A. Gray & Co.*, 467 U.S. 717, 729 (1984), it has no role to play in legislation significantly affecting fundamental rights. The State's approach is particularly damaging here, where the statutes the State seeks to defend have the extraordinary and undeniably burdensome effect of making private abortions unattainable for a significant number of women in Illinois and of gravely increasing the health risks of the abortion procedure for many others. Such a heavy burden on a constitutionally protected right, amply demonstrated in the record below, is more than sufficient to trigger heightened scrutiny of the degree to which the legislation serves the State's alleged purpose. *Webster*, 109 S. Ct. at 3062-63 (O'Connor, J.). Because the statutes challenged here actually undermine rather than promote the State's interest in protecting patient health, the courts below properly enjoined them as applied to abortion procedures.

I. ILLINOIS' STATUTORY REQUIREMENTS THAT ABORTIONS BE PERFORMED EXCLUSIVELY IN HOSPITALS OR AMBULATORY SURGICAL TREATMENT CENTERS UNCONSTITUTIONALLY BURDEN A WOMAN'S RIGHT TO TERMINATE HER PREGNANCY

Illinois has enacted a comprehensive and complicated regulatory scheme governing the performance of minor and major surgical procedures, including abortion. The central statute at issue is the Ambulatory Surgical

Treatment Center Act (ASTCA), which requires all facilities "devoted primarily" to the performance of surgical procedures, and "any facility" in which one abortion is performed, to meet the requirements of the ASTCA. Ill. Ann. Stat. ch. 111½, ¶ 157-8.3(A) (Smith-Hurd 1988). Together with Section 16(1) of the Medical Practice Act (MPA), the ASTCA operates to prevent physicians from performing abortions in physicians' offices or clinics. Severance and invalidation of those parts of the ASTCA and the MPA that prohibit any office-based abortions are not sufficient to render Illinois' scheme constitutional, however. The remainder of the ASTCA, which requires clinics devoted primarily to performing abortions to meet the ASTCA regulations places an enormous burden on the right to an abortion with no compensating benefit to maternal health, and therefore is also unconstitutional.

A. Section 16(1) Of The MPA And The Second Clause Of Paragraph 157-8.3(A) Of The ASTCA Preclude Physicians From Performing Abortions In Their Offices And Are Therefore Unconstitutional

Section 16(1) of Illinois' Medical Practice Act (MPA) prohibits physicians from performing an "elective abortion" outside a licensed ASTC, hospital or government-maintained facility. Ill. Ann. Stat. ch. 111, ¶ 4433(1) (Smith-Hurd 1978). A complementary provision is found in the second clause of ¶ 157-8.3(A) of Illinois' ASTCA, which defines an ASTC as "any facility in which a medical or surgical procedure is utilized to terminate a pregnancy." Failure to adhere to these statutes can result in (1) "disciplinary action" against the physician, including the revocation of a physician's license to practice, Ill. Ann. Stat. ch. 111, ¶ 4433, and (2) substantial fines levied against the operator of the facility, Ill. Stat. ch. 111½, ¶¶ 157-8.12-13 (Smith-Hurd 1988).

The unambiguous effect of these provisions is to "prohibit[] the performance of first-trimester abortions in physicians' offices." Juris. App. 51 (Coffey, J., dissenting). Although he disagreed with much of the majority's

analysis, Judge Coffey agreed that the district court properly enjoined enforcement of these provisions.[28] *Id.* at 53. In so doing, Judge Coffey endorsed the reasoning of the Supreme Court of Illinois, which in 1981 struck down a municipal ordinance whose language tracked the provisions at issue here: "'The right of a woman considering a first-trimester abortion to seek the advice and services of her obstetrician, gynecologist, or other physician in whom she has trust and confidence may not be so drastically curbed.'" *Id.* at 54, quoting *Village of Oak Lawn* v. *Marcowitz*, 86 Ill. 2d 406, 427 N.E.2d 36, 42 (1981). Because the Illinois Supreme Court was unanimous on this point, every judge who has ruled on a challenge to these provisions has concluded they are unconstitutional. The reasons for such unusual unanimity are plain.

First, these provisions create a substantial and undue burden on the ability of a woman to obtain an abortion with absolutely no compensating benefit to maternal health. The provisions are far more burdensome, for example, than the Georgia provisions invalidated in *Doe* v. *Bolton*, 410 U.S. 179 (1973). There, the Court struck down provisions that required hospital abortion committees and two licensed physicians in addition to the patient's physician to approve any abortion because they placed needless "obstacles in the path of the doctor upon whom [the patient] was entitled to rely." *Whalen* v. *Roe*, 429 U.S. at 605 n.33 (explaining decision in *Doe*). Illinois' provisions are qualitatively more burdensome than

[28] Judge Coffey also agreed with the majority's conclusion that the State's professed nonenforcement of the statute did not render plaintiffs' challenge moot. Juris. App. 49. As the majority held, correctly in *amici's* view, the record is "ambiguous" with regard to this policy; the State has never publicly announced its policy, *see* J.A. 246; and "[d]octors should not have to risk loss of their professional licenses to explore the contours of the asserted non-enforcement position." Juris. App. 14. *Cf. Doe* v. *Bolton*, 410 U.S. 179, 188 (1973) (physicians "should not be required to await and undergo a criminal prosecution as the sole means of seeking relief").

those in *Doe*: they actually *preclude* "surgeons who would otherwise perform first-trimester abortions out of their offices . . . from doing so." Juris. App. 51-52 (Coffey, J., dissenting).

For many women in rural areas, an abortion provided by her local physician may be the only realistic source for that service. Henshaw, Forrest & Van Vort, *Abortion Services in the United States, 1984 and 1985*, 19 Fam. Plann. Persp. 63, 65 (1987). In many cases, the inability to perform an abortion in the physician's office will mean the physician is unable to perform the abortion at all, for only a small fraction of hospitals allow abortions to be performed and very few of these are located in rural areas. *Id.* A substantial percentage of abortion providers perform fewer than 30 abortions per year, *id.* at 67, a figure consistent with a medical practice devoted not primarily to abortions but to servicing a range of health care needs for longtime patients. And there is no question that, even for those patients who can afford to travel long distances to find a facility willing to perform an abortion, the inability to have the identical procedure performed in the familiar and "more psychologically comforting setting" of the office of one's personal physician is a substantial burden. Juris. App. 23; J.A. 75. Illinois' provisions are therefore akin to the kinds of "absolute obstacles or severe limitations on the abortion decision" that the Court has found to constitute an "undue burden" on the patient's right in consultation with her physician to choose an abortion. *City of Akron*, at 464 (O'Connor, J., dissenting). See *Planned Parenthood* v. *Danforth*, 428 U.S. at 67-72 (invalidating spousal consent provision that granted "veto power" to spouse); *id.* at 78-79 (invalidating ban on one form of abortion procedure).

More striking still is the lack of any rational connection between the State's asserted legislative purpose—the protection of maternal health—and the statute itself. All of the physicians who testified at trial, including the

State's witness, agreed that first trimester abortions can and are being performed just as safely (if not more safely) in physicians' offices as in hospitals or ASTC's. See Juris. App. 52 (Coffey, J., dissenting); J.A. 110-23, 200-04. The testimony also brought out the irrationality of a state scheme that forbids physicians to perform first trimester abortions in offices or clinics, but allows them to perform D & C's, an analogous surgical procedure. J.A. 288-89. The medical evidence unequivocally supports that testimony. See *supra*, pp. 8-10 & n.26; *cf. Doe* v. *Bolton*, 410 U.S. at 195 (acknowledging evidence that abortions performed outside hospitals can be safe). Thus, a flat ban on the performance of first-trimester abortions in physicians' offices not only drastically burdens the right to obtain an abortion, it in no way furthers the State's legislative purpose.

Second, these provisions cannot withstand scrutiny under the Equal Protection Clause of the Fourteenth Amendment.[29] This was one of two alternative holdings of the Illinois Supreme Court, striking down analogous municipal legislation, in *Village of Oak Lawn* v. *Marcowitz*, 86 Ill. 2d 406, 427 N.E.2d 36, 42-43 (1981), and *amici* submit that that holding was plainly correct. The Illinois statutes operate to classify physicians into two groups, those who are allowed to perform certain minor surgical procedures in their offices (because they are not abortions) and those who are not allowed to perform such procedures (because they are abortions). The classification makes no sense in terms of the State's asserted purpose of protecting patient health, because the first trimester abortion is a safer procedure than many other procedures that the statutes allow physicians routinely to perform.[30] See *id.* at 288-89. These provisions therefore are not "based on differences that are reasonably related to the purpose of the Act[s] in which [they are] found," *Morey* v. *Doud*, 354 U.S. 457, 465 (1957), and accordingly must be invalidated as a violation of the physicians' basic right to the equal protection of the laws.

[29] Although not a basis for the court of appeals' decision, the Equal Protection argument was raised in the complaint, J.A. 22-23, and is therefore an appropriate alternative basis on which to affirm the judgment below.

[30] *Amici* do not question the State's ability to regulate physicians' office-based practices. Regulations mandating minimum professional credentials for performing certain surgical procedures are a pertinent example. *See Connecticut* v. *Menillo*, 423 U.S. 9 (1975). Unlike the regulations at issue here, Connecticut's statute was genuinely related to the State's interest in patient health, and did not arbitrarily classify physicians according to the surgical procedures they performed.

B. Because It Precludes Physicians From Performing Abortions In Offices Or Clinics "Primarily Devoted" To Abortions, The First Clause of Paragraph 157-8.3(A) Is Unconstitutional As Applied To First And Early Second Trimester Abortions

A substantial portion of Judge Coffey's dissent, and of the State's brief before this Court, is devoted to defending what remains of the Illinois statutory scheme after invalidation of the provisions Section 16(1) of the MPA and the second clause of the first sentence of ¶ 157-8.3(A) of the ASTCA. What remains are (1) the following definition of an ASTC: " 'Ambulatory surgical treatment center' means any institution, place or building devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures," Ill. Ann. Stat. ch. 111½, ¶ 157-8.3(A); and (2) an exhaustive set of regulations that "require ASTC's to be the functional equivalent of small hospitals." Juris. App. 115; see *id.* at 203-250 (reprinting 77 Ill. Admin. Code, Chapter 1, § 205, Subchapter b). According to the State and the dissent below, this remainder constitutes an "abortion neutral" statutory scheme that should be scrutinized solely to determine whether it is rationally related to the State's purpose of protecting patient health. See Br. for Appellants at 35-40; Juris. App. 55-64. Even assuming that this scheme may appropriately be de-

scribed as abortion-neutral,[31] the State's analytical approach finds no basis in long-established constitutional doctrine, and is inconsistent with the approach that a majority of this Court indicated only last Term to be appropriate in cases involving challenges to abortion regulations.

The degree of judicial scrutiny to be given a statute that in fact impinges on the exercise of a fundamental right has never depended on whether the statute was expressly designed to regulate only the exercise of that right or whether it has some broader application. In *Wisconsin* v. *Yoder*, 406 U.S. 205, 220 (1972), for example, this Court invalidated a state compulsory education law "of general applicability" *as it applied* to burden the plaintiffs' right to free exercise of religious beliefs. Similarly, as the Court reiterated in *Aptheker* v. *Secretary of State*, 378 U.S. 500 (1964), "'a governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedoms.'" *Id.* at 508, quoting *NAACP* v. *Alabama*, 377 U.S. 288, 307 (1963); see also *Sherbert* v. *Verner*, 374 U.S. 398, 403 (1963); *Shelton* v. *Tucker*, 364 U.S. 479, 488 (1960). When a statute infringes a fundamental right, the fact that the law can be characterized as one of general applicability does not affect the degree of scrutiny applied by the Court but rather restricts the scope of relief that may be appropriate to cure the constitutional violation. *E.g.*, *Wisconsin* v. *Yoder*, 406 U.S. at 236; *Sherbert* v. *Verner*, 374 U.S. at 410. No different analysis should apply in the abortion context. Accordingly, rather than accept the State's invitation to apply rational basis review, the

[31] *Amici* do not believe such a characterization is appropriate. The statute's declaration of policy and purpose explicitly refers to the regulation of abortions, Ill. Ann. Stat. ch. 111½, ¶ 157-8.2 (Smith-Hurd 1988), and the majority below found that the statute was "enacted primarily with abortion clinics in mind." Juris. App. 21.

Court should first examine the burden that the ASTCA places on the right to obtain an abortion. If it finds that the regulation, though general in nature, nevertheless significantly infringes the right, then the Court should analyze the degree to which application of the ASTCA to abortion clinics serves the State's asserted interest in protecting maternal health.

1. *Nature of the Burden*: As both courts found below, requiring Dr. Ragsdale's clinic to meet the licensing requirements of the ASTCA will cause that clinic to close. Juris. App. 22, 132. The reasons for that result are plain. First, the trial court found that "[t]he regulations, without question, cause abortion providers to incur[] great construction or renovation costs." Juris. App. 117. They require an abortion clinic to meet the requirements that are similar and in many cases identical to the requirements Illinois imposes on hospitals. See J.A. 114, 232, 298-99 (comparing ASTCA requirements to those of Illinois Hospital Licensing Act). A representative of the owner of the property rented to Dr. Ragsdale estimated that it would cost approximately $600,000 to $900,000 to bring his facility, already in "substantial" compliance, into full compliance with the ASTCA, J.A. 324, and Dr. Ragsdale estimated a cost of at least $240,000. Juris. App. 118.

Second, the ASTCA also operates to limit drastically the locations available to a prospective clinic. The regulations, which require fundamental changes to the structure of a building (such as the width of corridors and doorways and the size of rooms), will discourage landlords who want to keep their office space suitable for a variety of commercial uses from renting to clinics. More restrictive still is the requirement that all facilities devoted primarily to performing abortions be "identifiably separate from other facilities and functions." 77 Ill. Admin. Code, Chapter 1, § 205, Subchapter b, Subpart I, 205.1320(a). This requirement serves no discernible health-related purpose, but it does reduce the likelihood of finding rental space for a clinic by (1) eliminating

the option of locating a clinic in a building with other commercial tenants, and (2) making it easier to identify and harass those who provide and use the clinic's services. J.A. 197-99; see Forrest & Henshaw, *The Harassment of U.S. Abortion Providers*, 19 Fam. Plann. Persp. 9 (1987).[32] As the record below illustrates, potential landlords are apt to refuse to rent space to abortion providers if such tenancy will provoke public controversy. J.A. 125-30. Thus, the practical effect of the ASTCA's physical plant and "identifiably separate" requirements is to force potential abortion providers to construct facilities from the ground up, eliminating renters from the market altogether. Yet for Dr. Ragsdale, like most providers, such an option is no option at all, because construction costs for ambulatory health facilities are prohibitive, often costing more on a square foot basis than construction costs of hospitals.[33] See Department of Planning Services, United Hospital Fund of New York, *Construction Costs of Health Facilities* 3 (1978); *cf.* Riffer, *Can Surgicenters Stand Alone?*, Hospitals 44, 44-48 (July 20, 1986) (anticipating slow growth of surgicenters because of difficulty of recovering investment and increased competition from hospitals.)[34]

[32] In 1985, 47% of all abortion providers—and 95% of large-scale providers in the Midwest—reported experiencing significant episodes of harassment, including picketing of facilities, blocking patient access, harassment of patients who had been followed after leaving the clinic, picketing of homes of clinic employees, and demonstrations loud enough to be heard inside the clinic. Forrest *The Harassment of U.S. Abortion Providers* at 9-13. Obviously, no legitimate state interest is served by promoting such episodes.

[33] Application of the ASTCA to abortion clinics further obstructs their licensing by subjecting them to the public hearing and certificate-of-need requirements of Illinois' Health Facilities Planning Act, Ill. Ann. Stat. ch. 111½, ¶¶ 1151, *et seq.* (Smith-Hurd 1988). As the record below starkly demonstrates, the HFPA's requirements provide a forum for intimidation of potential owners/operators of clinics, subject clinics to a complex review process designed for qualitatively different types of facilities, and serve no state purpose. J.A. 123, 125-30, 259; Juris. App. 30-31, 130-31; *see also* L. Olson, Establishing Freestanding Ambulatory Surgery Centers 35 (AMA 1982) (certificate-of-need approval is "greatest hurdle" in establishing surgicenter); Riffer, *Can Surgicenters Stand Alone?* at 44-48 ("experts" predict decline in surgicenters due to low profitability and competition from hospitals).

The impact of the ASTCA is not limited to the closing of Dr. Ragsdale's clinic. According to the National Abortion Federation, over two-thirds of abortion providers nationwide are not in compliance with six or more of the ASTCA's design requirements.[35] Furthermore, because any provider whose practice is "devoted primarily" to surgical procedures must meet the ASTCA requirements, the ASTCA would operate to limit occasional providers from expanding their practice to meet demand. Plaintiff Margaret Moe, for example, whose facility now provides counseling and whose physicians occasionally perform some minor surgery, receives an average of 60 requests per week for abortions. J.A. 252. Under the "abortion-neutral" ASTCA, her facility could perform abortions only up to the point at which 49% of patient visits were for abortions and other surgical procedures.

The net effect of the ASTCA is to place an extraordinary burden on women in Illinois seeking an abortion. The closing of Dr. Ragsdale's clinic alone will mean that a significant number of women in Illinois will be completely denied access to any abortion service whatsoever. Dr. Ragsdale's clinic is the only provider of first trimester abortions in all of Northwest Illinois. J.A. 17. Many of his patients are poor, and receive abortions at his clinic

[34] There is thus no basis for the dissenting judge's speculation that a "physician-surgeon entrepreneur" would certainly move into the Northern Illinois area once Dr. Ragsdale's clinic closed. Juris. App. 66. That discussion assumes that abortion clinics can simply pop up, like fast-food franchises, wherever there is demand. This theory is obviously untenable in light of the formidable obstacles the ASTCA creates for siting and licensing a clinic, and is belied by the overwhelming statistical data demonstrating that many metropolitan and virtually all non-metropolitan counties lack any abortion provider whatsoever. *See supra*, pp. 10-11.

[35] Brief of National Abortion Federation and Planned Parenthood at 18-19.

at little or no cost. *Id.* Similarly, 90% of the patients at Margaret Moe's Elgin clinic and 50% of the patients at her Palatine Clinic do not own their own means of transportation, J.A. 260; some of these women, faced with the need to travel 50-100 miles to an abortion facility, have forgone abortions altogether. J.A. 264; see Tatalovich & Daynes, *The Geographic Distribution of U.S. Hospitals With Abortion Facilities*, 21 Fam. Plann. Persp. 81, 81 (1989) (local availability of abortion services affects use); Shelton, Brann & Schulz, *Abortion Utilization: Does Travel Distance Matter?*, 8 Fam. Plann. Persp. 260 (1976) (same).

For all other women in Northwest Illinois, the closing of Dr. Ragsdale's facility will mean significant delay, and therefore significantly increased health risks, in obtaining an abortion. The lack of a nearby abortion provider means that the patient's own physician may not be able to provide a referral, requiring additional time to find a provider. J.A. 154; see Torres & Forrest, *Why do Women Have Abortions?*, 20 Fam. Plann. Persp. 169, 174 (1988) (20% of women surveyed who had an abortion later than 16 weeks attributed delay to not knowing where to find a provider). The lack of a nearby provider also adds a logistical burden of arranging travel, which for patients without personal transportation and/or ready access to childcare can significantly delay obtaining an abortion. See J.A. 260-63 (many of Moe's patients lack access to private or adequate public transportation); Torres & Forrest, *Why do Women Have Abortions* at 174 (one in four women having abortions after 16th week attribute delay to lack of local provider and need to arrange transportation). Furthermore, because these logistical burdens substantially increase the financial cost of obtaining an abortion, many patients must delay their abortions in order to raise the necessary funds. See J.A. 263-65 (Moe's patients estimate total cost of abortion, including lost wages, travel and childcare costs, as two to three times the cost of the procedure itself); Lupfer & Silber, *How Patients View*

Mandatory Waiting Periods for Abortion, 13 Fam. Plann. Persp. 75, 77 (1981) (survey shows substantial increased costs associated with travel for abortion); Torres & Forrest, *Why do Women Have Abortions* at 174 (60% of women having abortions after 16th week attribute delay to needing time to raise money).

The burden of delay manifests itself in the unquestionable increase in health risk that these women face. "Within the first 12 weeks, the main risk to a woman who wants an abortion results from delay." Cates, Schulz, Grimes & Tyler, *The Effect of Delay and Method Choice On the Risk of Abortion Morbidity*, 9 Fam. Plann. Persp. 266, 267 (1977). The evidence is clear that "any delay" increases the risk of complications from abortion; *id.* at 268, and that "the major complication rate increases 91 percent when abortion is postponed from the eighth to the twelfth week." *Id.* at 267. Furthermore, delay once a woman has already reached 13 weeks gestation is particularly dangerous: "Nearly half of the deaths due to legal abortion [from 1975 to 1977] were the consequence of delay in obtaining abortion until past the 13th week of gestation." W. Hern, Abortion Practice 43 (1984). Lack of nearby abortion services are thus one of the principal community factors that contribute to major complications and death from legal abortion. *Id.*

These harms—inability to obtain an abortion, significantly increased risk of serious complications and death from delay in obtaining an abortion—constitute the kind of burden on a constitutional right that must be justified by the State on grounds more substantial than that they rationally serve a legitimate interest. Indeed, the burden that Illinois' ASTCA requirement creates is far more substantial than the burden created by many other statutes that this Court has invalidated.

For example, in *City of Akron* v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983), this Court struck down a municipal ordinance that required *second* trimester abortions to be performed in hospitals. *Id.* at

431-39. In contrast, at issue here are *state* regulations that apply to *first* as well as second trimester abortions, and are thus vastly more burdensome because over 90% of all abortions performed in America today are first-trimester abortions. Binkin, *Trends in Induced Legal Abortion Morbidity and Mortality*, 13 Clin. Obstet. Gynec. 83, 89 (1986). Moreover, the Akron ordinance was struck down notwithstanding the absence of any "evidence . . . to show that the two Akron hospitals that performed second-trimester abortions denied an abortion to any woman," and the lack of "evidence . . . that other hospitals in nearby areas did not provide second-trimester abortions." *City of Akron*, 462 U.S. at 466 (O'Connor, J., dissenting). In this case, however, the evidence is clear that the challenged statute and regulations will close the only large-scale provider of first-trimester abortions in the entire Northwest region of Illinois, J.A. 17, and that hospitals do not provide an adequate alternative, because the few that actually provide first-trimester abortions charge three times more than do clinics. J.A. 253. See also Tatalovich & Daynes, *The Geographic Distribution of U.S. Hospitals with Abortion Facilities* at 82-83 (only one in five Illinois hospitals provide abortions, and most such hospitals are in metropolitan areas); Henshaw, *Freestanding Abortion Clinics: Services, Structure, Fees*, 14 Fam. Plann. Persp. 248, 249 (1982) (in 1981, first-trimester abortions averaged $190 in clinics and $735 in hospitals).

The Illinois ASTCA also stands in stark contrast to those federal and state laws, upheld by this Court, that refused to provide financial assistance to those seeking an abortion. See *Webster* v. *Reproductive Health Services*, 109 S. Ct. 3040 (1989); *Harris* v. *McRae*, 448 U.S. 297 (1980); *Maher* v. *Roe*, 432 U.S. 464 (1977). Although in each of those cases the legislation had the effect of denying some women access to abortions, in each instance the law "imposed no restriction on access . . . that was not already there." *Maher*, 432 U.S. at 474. See *Webster*, 109 S. Ct. at 3052; *Harris*, 448 U.S. 297,

315-18 (1980). The Illinois statute challenged here is fundamentally different. It restricts access to abortions not by removing state subsidies, but by *affirmatively interfering* with the *private* provision of abortion services that would occur absent the challenged legislation. The ASTCA constitutes precisely the kind of "unreasonable official interference with private choice," *id.* at 328 (White, J., concurring), that must be subjected to heightened scrutiny.

2. *Relation to the State's Interest*: The most striking aspect of the ASTCA as applied to abortion clinics is its lack of any substantial relationship to the State's legitimate purpose of protecting maternal health. The safety of first trimester abortions chiefly depends not on the clinical setting but on gestational maturity, the procedure employed and the skill of the physician. See *supra*, pp. 6-7. ACOG's Standards explicitly state that abortions up to 14 weeks may be performed safely in physicians' offices and clinics, provided they are properly staffed and equipped. See ACOG Standards at 68. As the court of appeals found, the ASTCA and its regulations impose requirements "designed with procedures to be performed under general anesthesia in mind." Juris. App. 21. These requirements include many of the most expensive and burdensome physical requirements, such as the need for an oversized procedure room, doorways and corridors to accommodate general anesthetic and emergency equipment. None of these requirements is necessary for first-trimester abortions, which can be (and are) done safely under local anesthesia. See *supra*, p. 6. Nor do such requirements provide even an extra margin of safety, because abortions performed in such facilities are done with no less incidence of complications or death than those performed in clinics. *Id.*, p. 10.[36]

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[36] For example, the ASTCA regulations require installation of an expensive air filtration system. *See* 77 Ill. Admin. Code, Chapter 1, § 205, Subchapter b, Subpart J, 205.1540 (a)-(q). The purpose of such a system is to prevent airborne infection, which can occur during surgeries involving an incision. This system is unnecessary

In fact, the evidence in the record establishes that the net impact of applying the ASTCA to abortion clinics will be to worsen maternal health. The predictable and inevitable result of the ASTCA will be to reduce the number of abortion providers available to women, particularly those who live outside major metropolitan areas. Women in these areas, already disproportionately underserved by the inequitable distribution of abortion providers, will be delayed in their attempt to obtain an abortion, thereby adding materially and significantly to the risk posed by that procedure. In sum, because Illinois' scheme operates in practice to delay and deny women from exercising their constitutional right to obtain an abortion, it cannot survive any form of heightened constitutional scrutiny. Accordingly, the ASTCA, as it applies to abortion practices should be declared unconstitutional.

II. ILLINOIS' ABORTION COUNSELING REGULATION, SECTION 205.730(b)(2)(D), WHICH REQUIRES THAT ABORTION COUNSELORS NOT HAVE A FINANCIAL INTEREST IN THE PATIENT'S DECISION, UNCONSTITUTIONALLY PRECLUDES PHYSICIANS AND PAID STAFF FROM COUNSELING PATIENTS

Of the remaining aspects of the Illinois statutes and regulations applicable to abortions, one is of special concern to *amici*. It is the abortion counseling regulation, 77 Ill. Admin. Code, Chapter 1, § 205, Subchapter b, Subpart I, 205.730(b)(2)(D), which prevents a woman from discussing her unwanted pregnancy with her physician and his paid staff. Section 205.730(b)(2)(D) specifically requires that "counselors shall have no financial interest in the patient's decision." It is a subsection of Section 205.730(b), which requires that individual counseling be provided to all pregnant patients prior to the performance of any surgical procedure. Although *amici*

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in facilities performing first trimester abortions by suction curettage. J.A. 207, 216-17; *see supra*, pp. 6, 9 & n.24 and 10.

agree that counseling is an essential part of the abortion (or any surgical) process, this regulation unconstitutionally prevents the patient from seeking information and advice from the professional of her choice.

Courts have long recognized that physician-patient counseling is crucial to any meaningful opportunity for patients to exercise their right to control the medical treatment they receive, and is at the core of informed consent. See *Canterbury* v. *Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972) *cert. denied*, 409 U.S. 1064 (1972); A. Jonsen, M. Siegler & W. Winslade, Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine 61-65 (1986). In order to make the highly personal, emotionally charged decision whether to terminate a pregnancy, the patient must be adequately informed about her options, including potential risks and consequences in light of the particular factors of her individual case. ACOG Standards at 68; Landy, "Abortion Counselling—A New Component of Medical Care," 13 Clin. Obstet. Gynec. 33 (1986). Accordingly, this Court has "stressed repeatedly the central role of the physician, both in consulting with the woman about whether or not to have an abortion, and in determining how any abortion was to be carried out." *Colautti* v. *Franklin*, 439 U.S. 379, 387 (1979); see *City of Akron*, 462 U.S. at 442-49 (counseling is "primarily the responsibility of the physician").

Interpreted as it plainly reads, Section 205.730(b)(2)(D) prohibits a woman from consulting with her physician and paid staff concerning her decision whether to have an abortion. By prohibiting such consultation, the Illinois provision not only places a "governmental obstacle in the path of a woman", *McRae*, 448 U.S. at 315, but flatly preempts the requisite physician-patient counseling from taking place. A more complete intrusion on the physician-patient relationship is difficult to envision. *Cf. Planned Parenthood* v. *Danforth*, 428 U.S. 52, 67, n.8 (1976); *City of Akron*, 462 U.S. at 444-49;

Thornburgh v. *American College of Obstetricians and Gynecologists*, 476 U.S. 747, 759-64 (1986).

The State does not attempt to defend the statute's plain language, but argues instead that the statute is intended to apply only to nonphysician counselors who are paid according to the number of abortions at the facility. The State's argument is inconsistent with the plain meaning of the statute, however, and courts, in attempting to save a statute from constitutional attack, may not engage in "judicially rewriting it." *Aptheker* v. *Secretary of State*, 378 U.S. 500, 515 (1964). Not surprisingly, the panel below unanimously identified 250.730(b)(2)(D) as an onerous and unconstitutional provision, to be enjoined even if other aspects of the Illinois regulatory scheme were upheld. Juris. App. 28-29, 79. Because this provision places a unique and entirely unwarranted burden on a woman's decision whether to terminate her pregnancy, this Court should hold it unconstitutional.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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BRIEF

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IN THE

Supreme Court of the United States

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BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, *et al.*,
Appellants,

v.

RICHARD M. RAGSDALE, M.D., *et al.*,
Appellees.

On Appeal from the United States Court of Appeals for the Seventh Circuit

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BRIEF FOR SENATORS BOB PACKWOOD, ALAN CRANSTON, HOWARD METZENBAUM, BARBARA MIKULSKI, JOHN CHAFEE AND WILLIAM S. COHEN; REPRESENTATIVES DON EDWARDS, PATRICIA SCHROEDER, LES AUCOIN, VIC FAZIO, BILL GREEN, CLAUDINE SCHNEIDER AND CONSTANCE A. MORELLA; AND CERTAIN OTHER MEMBERS OF THE CONGRESS OF THE UNITED STATES AS *AMICI CURIAE* IN SUPPORT OF APPELLEES

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TABLE OF CONTENTS

	Page
INTEREST OF THE *AMICI CURIAE*	1
SUMMARY OF ARGUMENT	2
ARGUMENT	5
I. *STARE DECISIS*, CONSTITUTIONAL STABILITY AND INSTITUTIONAL LEGITIMACY STRONGLY COUNSEL ADHERENCE TO THE PRECEDENT ESTABLISHED IN *ROE* v. *WADE*, AND NO SPECIAL CIRCUMSTANCES EXIST THAT WOULD JUSTIFY A DEPARTURE FROM ITS PRINCIPLES	5
A. *Stare Decisis* Fosters Respect For The Law And The Court, And It Preserves Settled Expectations Necessary For Individuals To Plan Their Lives Free Of Shifting Governmental Interference	5
B. *Stare Decisis* Applies With Special Force To The Principles Of *Roe* v. *Wade*	8
II. SINCE *ROE* v. *WADE* IS NEITHER "UNSOUND IN PRINCIPLE" NOR "UNWORKABLE IN PRACTICE," THERE IS NO OCCASION FOR ITS MODIFICATION BY THIS COURT	11
A. *Roe* v. *Wade* Is Wholly Consistent With The Constitutional Protection Of Fundamental Privacy And Liberty Interests	11
B. *Roe* v. *Wade* Cannot Be Eroded Without Imperiling Other Important Aspects Of Privacy And Liberty	15
III. OVERRULING OR ERODING *ROE* v. *WADE* WOULD NOT REALIZE ANY COMPELLING GOVERNMENTAL INTEREST AND WOULD HAVE PROFOUNDLY ADVERSE CONSEQUENCES	19
CONCLUSION	25

TABLE OF AUTHORITIES

Cases: Page

Abele v. *Markle*, 351 F. Supp. 224 (D. Conn. 1972), *vacated*, 410 U.S. 951 (1973) 19
Arizona v. *Rumsey*, 467 U.S. 203 (1984) 2, 6, 9
Baker v. *Carr*, 369 U.S. 186 (1962) 9
Bellotti v. *Baird*, 443 U.S. 622 (1979) 10
Bowers v. *Hardwick*, 478 U.S. 186 (1986) 13
Burnet v. *Coronado Oil & Gas Co.*, 285 U.S. 393 (1932) 6, 10
Canada Packers, Ltd. v. *Atchinson, T. & S.F. Ry.*, 385 U.S. 182 (1966) 11, 20
Carey v. *Population Services International*, 431 U.S. 678 (1977) 16
City of Akron v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983) 5, 8, 9, 10, 21
City of Lakewood v. *Plain Dealer Publishing Co.*, 108 S.Ct. 2138 (1988) 8
Colautti v. *Franklin*, 439 U.S. 379 (1979) 10
CTS Corp. v. *Dynamics Corp.*, 481 U.S. 69 (1987) 8
Eisenstadt v. *Baird*, 405 U.S. 438 (1972) 10, 16
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Griswold v. *Connecticut*, 381 U.S. 479 (1965) 3, 10, 14, 16, 21
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TABLE OF AUTHORITIES—Continued

Page

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Miller v. *California*, 413 U.S. 15 (1973) 24
Monell v. *Department of Social Services*, 436 U.S. 658 (1978) 7, 25
Moore v. *City of East Cleveland*, 431 U.S. 494 (1977) 14
Moragne v. *State Marine Lines, Inc.*, 398 U.S. 375 (1970) 7
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Orozco v. *Texas*, 394 U.S. 324 (1969) 9
Patterson v. *McLean Credit Union*, 108 S.Ct. 2363 (1989) 5
Pierce v. *Society of Sisters*, 268 U.S. 510 (1925) 10, 13
Planned Parenthood Ass'n v. *Ashcroft*, 462 U.S. 476 (1983) 10
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Poe v. *Ullman*, 367 U.S. 497 (1961) 13, 19
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Webster v. *Reproductive Health Services*, 109 S.Ct. 3040 (1989) 8, 11, 16, 17, 18
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TABLE OF AUTHORITIES—Continued

	Page
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

No. 88-790

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, *et al.*,
Appellants,
v.
RICHARD M. RAGSDALE, M.D., *et al.*,
Appellees.

On Appeal from the United States Court of Appeals for the Seventh Circuit

BRIEF FOR SENATORS BOB PACKWOOD, ALAN CRANSTON, HOWARD METZENBAUM, BARBARA MIKULSKI, JOHN CHAFEE AND WILLIAM S. COHEN; REPRESENTATIVES DON EDWARDS, PATRICIA SCHROEDER, LES AUCOIN, VIC FAZIO, BILL GREEN, CLAUDINE SCHNEIDER AND CONSTANCE A. MORELLA; AND CERTAIN OTHER MEMBERS OF THE CONGRESS OF THE UNITED STATES AS *AMICI CURIAE* IN SUPPORT OF APPELLEES

INTEREST OF THE *AMICI CURIAE* [1]

Amici are a bipartisan group of members of the United States Senate and House of Representatives, as identified in the appendix. As members of a coordinate branch of government, sworn to uphold the Constitution of the United States, we are concerned with maintaining the stability and integrity of our system of constitutional government. We understand how central it is to our con-

[1] Appellants and appellees have consented to the filing of this brief. Letters of consent are on file with the Clerk of the Court.

stitutional system that certain fundamentally important rights of individuals are insulated from the shifting winds of politics. We are also aware that *stare decisis* plays a significant role in our constitutional system, and that it reassures individuals that fundamental rights, once secure, will not lightly be discarded.

We are particularly concerned that the overruling or erosion of *Roe* v. *Wade* and its progeny would call into question basic rights to privacy and liberty in matters of marriage, procreation and other fundamentally important liberties. A retreat from *Roe* v. *Wade* would subject profoundly intimate decisions to regulation under a patchwork of conflicting state and local laws which would be unenforceable against some and intolerably burdensome to others. Our concern with the constitutional protection of the rights of individuals and with the preservation of the rule of law lead us to urge this Court not to overrule *Roe* v. *Wade*.

SUMMARY OF ARGUMENT

The doctrine of *stare decisis* plays a central role in legitimating our constitutional system by ensuring that fundamental principles are grounded in the rule of law and not merely in individual preference. As the Court stated in *Vasquez* v. *Hillery*, 474 U.S. 254, 265-266 (1986), *stare decisis* "permits society to presume that bedrock principles are founded in the law rather than in the proclivities of individuals, and thereby contributes to the integrity of our constitutional system of government, both in appearance and in fact." By adhering to precedent, the Court allows individuals to plan their lives in reliance on established rules and to "satisfy reasonable expectations." *Helvering* v. *Hallock*, 309 U.S. 106, 119 (1940). Accordingly, "any departure from the doctrine of *stare decisis* demands special justification." *Arizona* v. *Rumsey*, 467 U.S. 203, 212 (1984).

There is no such justification for overruling *Roe* v. *Wade*. However the issue might have been decided as an

original matter, the burden now is squarely on those who would overrule *Roe* to show a compelling reason for departing from precedent. This they cannot do. *Roe* was decided with particular care, and a body of case law has evolved accepting and applying its principles. None of the usual reasons for departing from *stare decisis*, such as changed factual conditions or legal developments, is present here.

While the Court has sometimes overruled cases that have proven to be "unsound in principle" or "unworkable in practice," *Roe* fits neither category. This Court has firmly and repeatedly rejected the notions that the Due Process Clause has no substantive content and that the Constitution protects only the rights expressly mentioned in the Bill of Rights. The fundamental right identified in *Roe* is closely related to the procreational and family rights identified by the Court in cases such as *Meyer* v. *Nebraska*, 262 U.S. 390 (1923), and *Griswold* v. *Connecticut*, 381 U.S. 479 (1965). Like the right in *Roe*, none of the rights established in these precedents is explicitly named in the Constitution.

As its close relationship to these cases suggests, *Roe* cannot be eroded or overruled without calling into question other fundamental rights and liberties. For example, the right of contraception recognized in *Griswold* cannot meaningfully be distinguished from *Roe*'s protection of reproductive choice. Indeed, the refusal to protect a woman's choice to have an abortion would lead logically to a holding that compulsory abortion laws would be constitutional—a result abhorrent to our history and to our expectations as a free society. Yet overruling *Roe* or reducing procreational rights to the status of a mere liberty would subject those rights to the burdens of all minimally rational state regulation.

Finally, overruling *Roe* would not realize any compelling state interest and would in fact have substantial ad-

verse consequences. Criminalizing abortion, or enforcing regulations that would put safe and legal abortion beyond the reach of all but the affluent, would not eliminate abortions. Rather, it would force women to turn to delayed, dangerous and illegal abortions in place of the safe procedures currently guaranteed them under the Constitution. The burden imposed by the inconsistent state laws that would result from returning the abortion question to the raw political process would fall most heavily on the poorest women in our society, who would be unable to afford to travel to states permitting the procedure.

As members of Congress, we have a legitimate concern that such conflicting regulation would produce unreasonable and unproductive differences among states and increase the burdens on an already overtaxed health care system. Whether one favors or opposes abortion as a matter of personal conscience, it is difficult to see how subjecting critically important individual decisions about procreation to state and local politics would produce anything other than chaotic and undesirable results. For all these reasons, the Court should not, for the first time, withdraw or erode a fundamental right of such central importance as the one established in *Roe* v. *Wade*.

ARGUMENT

I. *STARE DECISIS*, CONSTITUTIONAL STABILITY, AND INSTITUTIONAL LEGITIMACY STRONGLY COUNSEL ADHERENCE TO THE PRECEDENT ESTABLISHED IN *ROE* v. *WADE*, AND NO SPECIAL CIRCUMSTANCES EXIST THAT WOULD JUSTIFY A DEPARTURE FROM ITS PRINCIPLES.

A. *Stare Decisis* Fosters Respect For The Law And The Court, And It Preserves Settled Expectations Necessary For Individuals To Plan Their Lives Free Of Shifting Governmental Interference.

The principle of respect for precedent embodied in the doctrine of *stare decisis* "permits society to presume that bedrock principles are founded in the law rather than in the proclivities of individuals, and thereby contributes to the integrity of our constitutional system of government, both in appearance and in fact."[2] Thus, *stare decisis* "demands respect in a society governed by the rule of law."[3] The Court reaffirmed just last Term that "it is indisputable that *stare decisis* is a basic self-governing principle within the Judicial Branch, which is entrusted with the sensitive and difficult task of fashioning and preserving a jurisprudential system that is not based upon 'an arbitrary discretion.'"[4] In short, "[t]he rule of law depends in large part on adherence to 'the doctrine of *stare decisis*."[5]

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[2] *Vasquez* v. *Hillery*, 474 U.S. 254, 265-266 (1986).

[3] *City of Akron* v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 420 (1983).

[4] *Patterson* v. *McLean Credit Union*, 109 S. Ct. 2363, 2370 (1989) (quoting *The Federalist* No. 78, at 490 (H. Lodge ed. 1888) (A. Hamilton)).

[5] *Welch* v. *Texas Dep't of Highways and Public Transportation*, 483 U.S. 468, 478-479 (1987) (plurality op.).

While *stare decisis* is not an "inexorable command" in constitutional cases,[6] fidelity to precedent is particularly significant in cases involving what the Court in *Vasquez* v. *Hillery* called the "bedrock principles" [7] by which we govern ourselves and plan our lives. The Court therefore "should not be unmindful, even when constitutional questions are involved, of the principle of *stare decisis*, by whose circumspect observance the wisdom of this Court as an institution transcending the moment can alone be brought to bear." [8] In departing from precedent, the Court "become[s] the breeder of fresh doubt and confusion in the public mind as to the stability of our institutions." [9] Accordingly, even in constitutional cases, "any departure from the doctrine of *stare decisis* demands special justification." [10]

The role of *stare decisis* in furthering stability and institutional legitimacy in constitutional cases is clear. Overruling a constitutional precedent "may well raise doubts both as to the Court's impersonality and as to the principled foundations of its decisions. * * * This is especially true when the change in law has occurred over a comparatively short period of time marked by a significant alteration in the Court's personnel." [11]

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[6] *Burnet* v. *Coronado Oil & Gas Co.*, 285 U.S. 393, 405 (1932) (Brandeis, J., dissenting).

[7] 474 U.S. at 265.

[8] *Green* v. *United States*, 355 U.S. 184, 215 (1957) (Frankfurter, J., dissenting).

[9] *Smith* v. *Allwright*, 321 U.S. 649, 670 (1944) (Roberts, J., dissenting).

[10] *Arizona* v. *Rumsey*, 467 U.S. 203, 212 (1984).

[11] Israel, *Gideon* v. *Wainwright: The "Art" of Overruling*, 1963 Sup. Ct. Rev. 211, 218. *See Florida Dep't of Health* v. *Florida Nursing Home Ass'n*, 450 U.S. 147, 154 (1981) (Stevens, J., concurring) ("Citizens must have confidence that the rules on which they rely in ordering their affairs * * * are rules of law and not merely the opinions of a small group of men who temporarily occupy high office."); Monaghan, *Stare Decisis and Constitutional Adjudication*, 88 Colum. L. Rev. 723, 752 (1988) ("[A]dherence to precedent can contribute to the important notion that the law is impersonal in character, that the Court believes itself to be following a 'law which binds [it] as well as the litigants.'") (quoting A. Cox, *The Role of the Supreme Court in American Government* 50 (1976)).

Both the legitimacy and utility of law depend in large part on whether legal rules "furnish a clear guide for the conduct of individuals, to enable them to plan their affairs with assurance against untoward surprise." [12] Thus, in addition to forming a foundation for institutional legitimacy, *stare decisis* "is rooted in the psychologic need to satisfy reasonable expectations." [13] Adherence to precedent promotes the continuity and "predictability required for the ordering of human affairs over the course of time." [14] These concerns are particularly relevant in constitutional cases, such as the abortion precedents, that directly affect the conduct of individuals.[15]

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[12] *Moragne* v. *State Marine Lines, Inc.*, 398 U.S. 375, 403 (1970).

[13] *Helvering* v. *Hallock*, 309 U.S. 106, 119 (1940).

[14] *Williams* v. *Florida*, 399 U.S. 78, 127 (1970) (Harlan, J., concurring in part and dissenting in part). *See also Monell* v. *Department of Social Services*, 436 U.S. 658, 700 (1978) (Court must consider extent to which "'individuals may have arranged their affairs in reliance on the expected stability of the decision'") (quoting *Monroe* v. *Pape*, 365 U.S. 167, 221-222 (1961) (Frankfurter, J., dissenting)).

[15] *See Thornburgh* v. *American College of Obstetricians and Gynecologists*, 476 U.S. 747, 780-781 (1986) (Stevens, J., concurring) ("Nor does the fact that the doctrine of *stare decisis* is not an absolute bar to the reexamination of past interpretations of the Constitution mean that the values underlying the doctrine may be summarily put to one side. There is a strong public interest in stability, and in the orderly conduct of our affairs, that is served by a consistent course of constitutional adjudication."). By contrast, cases such as *Garcia* v. *San Antonio Metropolitan Transit Authority*, 469 U.S. 528 (1984), involved questions of intergovernmental relations that did not form the basis for reliance by individuals in planning their conduct.

At the most basic level, faithfulness to precedent "helps us plan our lives, have some degree of repose, and avoid the paralysis of foreseeing only the unknown." [16]

B. *Stare Decisis* Applies With Special Force To The Principles Of *Roe* v. *Wade*.

However one might have approached the constitutionality of abortion restrictions as a matter of first impression, the Court no longer "write[s] on a clean slate." [17] The Court rather must decide the questions before it mindful of the precedents established in *Roe* v. *Wade* [18] and its progeny.[19] Thus, quite simply, "[w]hether *Roe*

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[16] Schauer, *Precedent*, 39 Stan. L. Rev. 571, 597 (1987).

[17] *Welch* v. *Texas Dep't of Highways and Public Transportation*, 483 U.S. at 493 (plurality op.).

[18] 410 U.S. 113 (1973).

[19] The controlling decisions of the Court are *Roe*, *Akron* v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983), and *Thornburgh* v. *American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986). On the crucial issue of the continued adherence to *Roe*, the plurality opinion in *Webster* v. *Reproductive Health Services*, 109 S. Ct. 3040 (1989), did not command a majority of the Members and therefore is not regarded as a decision of the Court. *See, e.g., CTS Corp.* v. *Dynamics Corp.*, 481 U.S. 69, 81 (1987). Rather, " 'the holding of the Court may be viewed as the position taken by those Members who concurred in the judgment on the narrowest grounds.' " *City of Lakewood* v. *Plain Dealer Publishing Co.*, 108 S. Ct. 2138, 2148 n.9 (1988) (quoting *Marks* v. *United States*, 430 U.S. 188, 193 (1977)). Accordingly, the controlling opinion in *Webster* is Justice O'Connor's opinion concurring in part and concurring in the judgment. Justice O'Connor, together with the four dissenting Justices, refused to cast doubt on *Roe*. Rather, her opinion resolves the issues in *Webster* on the basis of the Court's previous abortion decisions. Indeed, the dissenting Justices agreed with Justice O'Connor that the Missouri viability-testing provision—as interpreted by the plurality—is consistent with *Roe*. *See Webster*, 109 S. Ct. at 3070 (Blackman, J., concurring in part and dissenting in part); *id.* at 3079 (Stevens, J., concurring in part and dissenting in part). Thus, *Webster* was

should be overruled is a question not reducible to whether *Roe* was decided correctly." [20]

As the Court noted in *Akron*, there are "especially compelling reasons" to remain faithful to *Roe*.[21] These include the exceptional care with which the case was decided and the body of precedent that has evolved in which its principles have been accepted and elaborated.[22] The Court's refusal to overrule *Roe* in *Webster*, on full briefing of the parties and numerous *amici*, further reflects the extent to which the abortion precedents have become a firmly embedded feature of constitutional law.

There are no compelling circumstances that might provide the "special justification" [23] to warrant a departure from these decisions. While changed factual conditions have provided such justification in the past,[24] that principle has no application to the present case. The fundamental right recognized in *Roe*—the right of a woman,

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decided on the basis of the continued vitality of *Roe*, *Akron* and *Thornburgh*, and those cases (together with Justice O'Connor's opinion in *Webster*) form the body of precedent entitled to respect under the doctrine of *stare decisis*.

[20] Monaghan, *supra* n.11, at 747. *See also, e.g., id.* at 758 ("[e]ven an 'overriding conviction' of prior error is not enough" to justify departure from constitutional precedent); *Orozco* v. *Texas*, 394 U.S. 324, 327-328 (1969) (Harlan, J., concurring).

[21] 462 U.S. at 420 n.1.

[22] *See id.*

[23] *Arizona* v. *Rumsey*, 467 U.S. at 212.

[24] *See, e.g., NLRB* v. *Jones & Laughlin Steel Corp.*, 301 U.S. 1 (1937) (modifying construction of Commerce Clause in light of changed economic conditions); *Mapp* v. *Ohio*, 367 U.S. 643 (1961) (applying exclusionary rule to the states when other remedies had proven incapable of guaranteeing Fourth Amendment rights); *Baker* v. *Carr*, 369 U.S. 186 (1962) (ruling that reapportionment challenges are justiciable when state legislatures had failed to correct malapportionment).

rooted in privacy concerns, "to make the highly personal choice whether or not to terminate her pregnancy" [25]—is a purely legal proposition not dependent on transitory factual assumptions. It is therefore entitled to the strongest deference under the doctrine of *stare decisis*.[26]

To be sure, changed legal developments also have formed the basis for overruling precedents that have become "sport[s] in the law, * * * inconsistent with what preceded and what followed."[27] As with the doctrine of changed factual conditions, however, this principle is inapposite to *Roe*. As discussed in more detail below, the fundamental right of reproductive autonomy identified in *Roe* followed directly from the Court's cases recognizing fundamental rights in procreation,[28] childrearing,[29] marriage,[30] and contraceptive choice.[31] And subsequently, *Roe* repeatedly has been relied on to invalidate legislation that conflicts with the right recognized in that case.[32]

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[25] *Akron*, 462 U.S. at 420 n.1. *See also, e.g., Thornburgh*, 476 U.S. at 759 ("The States are not free, under the guise of protecting maternal health or potential life, to intimidate women into continuing pregnancies.").

[26] *See, e.g., Burnet* v. *Coronado Oil & Gas Co.*, 285 U.S. at 410-411 (Brandeis, J., dissenting).

[27] *Screws* v. *United States*, 325 U.S. 91, 112 (1945) (plurality op.). *See also, e.g., United States* v. *Darby*, 312 U.S. 100 (1941); *Hudgens* v. *NLRB*, 424 U.S. 507 (1976); *Ferguson* v. *Skrupa*, 372 U.S. 726 (1963).

[28] *See Skinner* v. *Oklahoma*, 316 U.S. 535 (1942).

[29] *See Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925).

[30] *See Loving* v. *Virginia*, 388 U.S. 1 (1967).

[31] *See Griswold* v. *Connecticut*, 381 U.S. 479 (1965); *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972).

[32] *See Thornburgh*, 476 U.S. 747; *Akron*, 462 U.S. 416; *Planned Parenthood Ass'n* v. *Ashcroft*, 462 U.S. 476 (1983); *Colautti* v. *Franklin*, 439 U.S. 379 (1979); *Bellotti* v. *Baird*, 443 U.S. 622 (1979); *Planned Parenthood* v. *Danforth*, 428 U.S. 52 (1976). By

Roe also has been accepted and applied even in those cases where legislation has been upheld.[33] Thus, there have been no developments in legal doctrine that would justify a departure from *stare decisis* in this instance.

For all these reasons, the principles of *stare decisis* counsel the strongest continued respect for *Roe* v. *Wade*. The Court would therefore be justified in overruling its abortion precedents only upon a demonstration that they have proven "unsound in principle and unworkable in practice," [34] or that they have been attended by "particularly unfortunate consequences." [35] As discussed in Parts II and III below, neither showing can be made in this case.

II. SINCE *ROE* v. *WADE* IS NEITHER "UNSOUND IN PRINCIPLE" NOR "UNWORKABLE IN PRACTICE," THERE IS NO OCCASION FOR ITS MODIFICATION BY THIS COURT.

A. *Roe* v. *Wade* Is Wholly Consistent With The Constitutional Protection Of Fundamental Privacy And Liberty Interests.

The Court's recognition in *Roe* v. *Wade* that a woman has a right to make her own decision about whether to continue a pregnancy is firmly grounded in the Constitution's express guarantee that liberty shall not be denied without due process of law. The decision was thus not a deviation from prior law; it stemmed directly from the Court's prior decisions recognizing that the rights to

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contrast, no law was ever held unconstitutional on the basis of *National League of Cities* v. *Usery*, 426 U.S. 833 (1976), before it was overruled in *Garcia*, 469 U.S. 528 (1984).

[33] *See Webster* and note 19, *supra*; *Maher* v. *Roe*, 432 U.S. 464 (1977); *Harris* v. *McRae*, 448 U.S. 297 (1980).

[34] *Garcia*, 469 U.S. at 546.

[35] *Canada Packers, Ltd.* v. *Atchison, T. & S.F. Ry.*, 385 U.S. 182, 184 (1966) (per curiam).

procreation, childrearing, marriage and contraceptive choice are fundamentally important liberties.[36]

The Fourteenth Amendment guarantees that "No state shall * * * deprive any person of * * * liberty * * * without due process of law." The framers of this amendment chose not to include any particularized list of the

[36] The contention that *Roe* v. *Wade* has proven "unworkable in practice" can easily be put to one side: there is simply no support for this proposition. With any constitutional principle there will always be a question of how much specific guidance concerning application of the principle this Court should provide to legislators and lower courts. This is a prudential question, one calling for the exercise of judicial discretion, and not a matter that goes to the heart of the legitimacy of the constitutional principle itself or to its functional workability.

Any disinterested review of post-*Roe* litigation would show that the principles of that decision have been at least as "workable" as other constitutional doctrines. Neither this Court nor the lower courts, for example, have encountered any particular difficulty in applying the common-sense distinction that a state may regulate abortions to protect a woman's health when her health interests are genuinely implicated, and not otherwise. *Compare Garcia* v. *San Antonia Metropolitan Transit Authority*, 469 U.S. at 539 ("We find it difficult, if not impossible, to identify an organizing principle that places each of the cases [applying *National League of Cities*] in [one] group on one side of the line and each of the cases in the [other] group on the other side.").

Moreover, *Roe* has not proven especially difficult to apply—in spite of the passage of state laws and local ordinances deliberately close to the line of permissibility. There will always be, in all areas of law, close calls to be made. The existence of inevitable distinctions at the margin of a constitutional doctrine does not in any way suggest that the underlying principle is unsound. The constitutional principles of freedom of speech and of the press, for example, are still considered to be fundamentally sound notwithstanding cases numbering the hundreds drawing lines between the traditional public form, the designated public forum, and the non-public forum. *See Gannett Satellite Information Network* v. *Berger*, 716 F. Supp. 140, 146, *dismissed*, 1989 U.S. Dist. Lexis 7548 (D.N.J. 1989), discussing these distinctions, and in particular, the numerous cases dealing with distinctions in constitutional law governing restrictions on the placement of newsrack machines.

"liberties" to be protected, but rather added to the national Constitution a general principle that individuals were to be free to exercise important, but not specifically denoted, liberties. As Justice Harlan once observed, the suggestion that the Due Process Clause should be limited to a guarantee of procedural fairness has not been followed. "Were due process merely a procedural safeguard it would fail to reach those situations where the deprivation of life, liberty or property was accomplished by legislation which by operating in the future could, given even the fairest possible procedure in application to individuals, nevertheless destroy the enjoyment of all three." [37] More recently, the Court has noted that "*the cases are legion* in which [the Due Process Clauses of the Fifth and Fourteenth Amendments] have been interpreted to have substantive content, subsuming rights that to a great extent are immune from federal or state regulation or proscription." [38]

The right of an individual to make her own choice about critical matters of reproduction and family formation is an interest soundly grounded in this constitutional protection of liberty. From the time of *Meyer* v. *Nebraska* [39] in 1923 and *Pierce* v. *Society of Sisters* [40] in 1925, this Court has recognized that a couple's decision about how to raise and educate their children is an especially important liberty. From the time of *Skinner* v. *Oklahoma* [41] in 1942, this Court has recognized that a state needs an extraordinary justification when it acts to control a person's reproductive capacity. In *Loving* v.

[37] *Poe* v. *Ullman*, 367 U.S. 497, 541 (1961) (dissenting opinion).

[38] *Bowers* v. *Hardwick*, 478 U.S. 186, 191 (1986) (emphasis added).

[39] 262 U.S. 390 (1923).

[40] 268 U.S. 510 (1925).

[41] 316 U.S. 535 (1942).

Virginia [42] in 1967, this Court recognized that these principles protect the liberty to decide whether and whom to marry. In *Griswold* v. *Connecticut* [43] in 1965, this Court recognized that the freedom to decide whether or not to conceive children was of fundamental constitutional importance. The fundamental constitutional importance of being free from governmental coercion in making decisions about family formation was reaffirmed in *Moore* v. *City of East Cleveland* [44] in 1977.[45]

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[42] 388 U.S. 1 (1967).

[43] 381 U.S. 479 (1965).

[44] 431 U.S. 494 (1977).

[45] Like the right to terminate a pregnancy, none of these aspects of liberty is explicitly mentioned in the text of the Constitution. And, like the right to terminate a pregnancy, all are fundamental aspects of the "liberty" that is expressly protected against governmental intrusion by the Fourteenth Amendment. Other liberties that are surely fundamental—such as the liberty to be free of governmentally *compelled* abortion (discussed *infra*)—are not specifically listed anywhere in the Constitution. The argument that the Constitution does not mention abortion thus utterly fails to distinguish *Roe* from any of the liberties that the Court, throughout this century, has recognized as fundamental. Since the Fourteenth Amendment does not specify *any* particularized liberties, protecting only those aspects of liberty that are specifically described would not leave *any* of this Court's fundamental liberty decisions standing.

Moreover, any attempt to limit fundamental liberties to those for which there is a historical tradition of protection at the "most specific level" would be contrary to the Court's decisions in cases such as *Loving* v. *Virginia*, which struck down state laws forbidding interracial marriage. Before *Loving* there had unquestionably been a long and intensely emotional tradition of *not* protecting interracial marriages. It was the Court's understanding of more general constitutional principles—the right to form a family and racial equality—that allowed the Court to find anti-miscegenation laws both a violation of the Equal Protection Clause *and* a violation of the fundamental liberty to marry protected by the Due Process Clause of the Fourteenth Amendment.

B. *Roe* v. *Wade* Cannot Be Eroded Without Imperiling Other Important Aspects Of Privacy And Liberty.

There is no principled basis for eroding the protection of a woman's interest in deciding whether to continue a pregnancy as a fundamental liberty while retaining six decades of cases supporting fundamental liberty interests in other vital areas of privacy. Assuming that this Court is not prepared to abandon those precedents, the burden is on those who urge a retreat from *Roe* to demonstrate that a woman's personal decision to terminate a pregnancy is not a fundamental liberty of the same magnitude as other protected interests in procreational choice and family formation. This burden cannot be met.

Restrictive state abortion laws require women (and only women) to endure government-mandated physical intrusions significantly more substantial than those the Court has held to violate the constitutional principle of bodily integrity;[46] by imposing mandatory childbearing on pregnant women, government itself creates significant risk of physical harm to women. The health and medical risks for women compelled by law to forgo an abortion procedure are substantial. All pregnancies present a significant risk to a woman's health, a risk that women are willing to assume when they desire to have a child and build a family, but a profound imposition upon an individual when mandated by government rule. Restrictive abortion laws, moreover, allow the state to take control of a woman's basic choices about reproduction and

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[46] *Cf. Winston* v. *Lee*, 470 U.S. 753 (1985), in which the state sought to compel surgical removal of a bullet from beneath the skin of a murder suspect, a procedure the lower court concluded would pose "minimal" or "very low" risk. *Lee* v. *Winston*, 717 F.2d 888, 900 (4th Cir. 1983). The Supreme Court held that "a compelled surgical intrusion into an individual's body * * * implicates expectations of privacy and security of such magnitude that the intrusion may be 'unreasonable' even if likely to produce evidence of a crime." 470 U.S. at 759.

family formation. It is difficult to conceive of a meaningful concept of fundamental "liberty" that does not encompass protection of a person's reproductive choice. Government-compelled childbirth is an extraordinary intervention into a person's life.

If *Griswold* is to remain good law, how can one fail to conclude that women have a fundamental liberty interest in deciding whether or not to terminate a pregnancy? The United States, in its *amicus* brief and in oral argument in *Webster*, took the position that the Court could retain *Griswold* even if it overturned *Roe*'s conclusion that there was a fundamental liberty interest in choosing whether to terminate a pregnancy. Squinting at *Griswold*, the United States noted a reference in one of the *Griswold* opinions to the possibility of "police searches of marital bedrooms for the tell-tale signs of the use of contraceptives," and suggested that *Griswold* could be read as a narrow fourth amendment search and seizure case.[47] This reading of *Griswold*, however, would reduce it to a largely inconsequential decision. If *Griswold* only protects couples from police searches of marital bedrooms, states would be free to criminalize all manufacture, sale and distribution of every kind of birth control device. National, state and local governments would be free to deny American citizens access to birth control—as long as the government enforced its ban by means other than searching marital bedrooms.[48]

The exercise of rights of contraception is not necessarily more "private" than the exercise of abortion choice. Under certain state statutes, which attempt to define abortion as occurring at any point after fertilization of an ovum by a sperm, full enforcement of a ban

[47] Brief Amicus Curiae for the United States at 12 n.9.

[48] This limited reading would obviously require the overruling of *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972), and *Carey* v. *Population Services International*, 431 U.S. 678 (1977), cases protecting the sale and distribution of contraceptives.

on all abortions would involve the most intrusive conceivable searches for evidence of use of pills and intrauterine devices that may function after fertilization.

The case for viewing the choice to terminate a pregnancy as a fundamental right integral to privacy and "ordered liberty" is perhaps most powerful when it is realized that if the choice is anything less than fundamental—even simply a liberty interest—states (and perhaps 14,000 local governments) would need only a minimal justification to *require* women to undergo abortions. This issue was raised and explored last Term in the *Webster* argument. If a woman's liberty of reproductive choice is less than fundamental, and is seen as a "mere liberty interest" subject to all "rational" state regulation, state or local governments could *require* women to have abortions as a matter of routine exercise of the police power. If only a rational basis is required to justify such statutes, a state or local governmental body could pass laws burdening women who chose childbirth over abortion and successfully defend such laws on the grounds that they "rationally" advanced the governmental objective of reducing housing shortages and public school overcrowding.[49]

Even if the Court were to overrule *Roe*'s holding that abortion choice is a fundamental liberty, the United States argued in *Webster*, a *compulsory* abortion law

[49] The possibility that some government officials would coerce women into having abortions if *Roe* were overturned is not necessarily a farfetched hypothetical. *See* "7 Contend Correction Dept. Urged Abortions for Guards," *New York Times*, May 24, 1989, p. B3, col. 1 ("Seven present and former New York City Correction officers contended yesterday that the Correction Department regularly told pregnant officers to have abortions or resign."). *See also* "Correction Officials Fined Over Abortions," *New York Times*, October 4, 1989, p. B2, col. 6 ("A senior official of New York City's Department of Correction has resigned and four others have been penalized in an investigation into charges that the department has told pregnant correction officers to have abortions or resign.").

could still be struck down as an unconstitutional seizure, because in such a case the state would be "violently taking hands on, laying hands on a woman and submitting her to an operation." [50] This attempt to distinguish between compelling an abortion and compelling childbirth is wholly inadequate. It would obviously not be necessary for the state to seize a woman physically in order to enforce a compulsory abortion law; a pregnant woman's unlawful failure to undergo an abortion could be enforced by after-the-fact civil or criminal fines, jail sentences, or other sanctions, including the punitive withholding of government benefits.

In each case, a woman's decision about how to treat her pregnancy would be overridden by the government; in the one case the state would impose sanctions on those women who had chosen to terminate a pregnancy; in the other the government would impose sanctions on those who had chosen to give birth. In neither case would it be necessary for the government to "[lay] hands on a woman and [submit] her to an operation" in order to substitute the government's decision for the choice she would have made. In the case of compelled abortion, a woman would be forced, by threat of sanctions, to undergo a medical procedure; in the other, a woman would be forced, by threat of sanctions, to undergo childbirth, a process more dangerous than terminating a pregnancy by abortion.[51] If this Court were to overrule or erode *Roe* v. *Wade* and end the fundamental liberty protection of a

[50] *See* Tr. of oral argument in *Webster*.

[51] *See* Le Boet, Grimes & Cates, *Mortality from Abortion and Childbirth: Are the Populations Comparable?*, 248 J.A.M.A. 188, 190 (1982). Indeed, since in nearly one in four cases childbirth is by caesarean section, many women who would be forced by restrictive abortion laws to undergo childbirth will effectively be forced by the government to undergo a major surgical procedure as well. *See* Placet & Taffel, *Recent Patterns in Caesarean Delivery in the United States*, 15 Obstet. Gynec. Clin. N.A. 607 (1988). *Compare Winston* v. *Lee*, discussed *supra* n.46.

woman's reproductive choice, it is by no means clear what constitutional principle would remain that would restrain any government from imposing abortion on a woman who wanted to bear a child.

III. OVERRULING OR ERODING *ROE* v. *WADE* WOULD NOT REALIZE ANY COMPELLING GOVERNMENTAL INTEREST AND WOULD HAVE PROFOUNDLY ADVERSE CONSEQUENCES.

As discussed above, the values of legitimacy, stability and reliance underlying the doctrine of *stare decisis* would be furthered by the Court's continued adherence to the basic principle of *Roe* v. *Wade*—the principle that a woman's reproductive liberty interest is so fundamental that any government restrictions on her right must be shown to advance a compelling governmental interest. Some parties and *amici* before this Court have argued in the past and will continue to argue that restrictive abortion laws do advance a governmental interest of protecting all potential life from the moment of conception. As Justice Harlan once wrote, however, "[T]he mere assertion that the action of the State finds justification in the controversial realm of morals cannot justify alone any and every restriction it imposes." [52]

And in any event, it has not been shown that a return to the pre-*Roe* era would actually serve any such goal.[53] If governments are free to criminalize abortions, or to

[52] *Poe* v. *Ullman*, 367 U.S. at 545 (dissenting opinion); *see also Weinberger* v. *Wiesenfeld*, 420 U.S. 636, 648 (1975) ("mere recitation" of governmental interest insufficient).

[53] Moreover, as Judge Newman noted in an opinion striking down Connecticut's restrictive abortion law the year before *Roe* was decided: "A compelling state interest has generally been one where the nature of the interest was broadly accepted. * * * No decision of the Supreme Court has ever permitted anyone's constitutional right to be directly abridged to protect a state interest which is subject to such a variety of personal judgments." *Abele* v. *Markle*, 351 F. Supp. 224, 230 (D.Conn. 1972), *vacated*, 410 U.S. 951 (1973).

promulgate regulations placing them beyond the reach of women who are not affluent, the principal consequence will not be the "protection of all potential human life," but rather the substitution of delayed, dangerous and illegal abortions for safe and legal abortions.

The respect to be accorded *Roe* is thus all the more compelling because of the substantial adverse consequences that overruling this particular precedent would entail. "[D]eparture from precedent may sometimes threaten the stability and continuity of the political order and should therefore be avoided: *Roe* provides a ready example." [54]

The Court has made clear that *stare decisis* commands respect for precedent to avoid harmful results, regardless of the present Court's view of the merits of the original decision. "Even an 'overriding conviction' of prior error is not enough * * * [where] the effects of the precedents are not harmful, and overruling the precedents would produce exceptionally harmful effects." [55]

The pernicious consequences of overruling *Roe*—or of eroding its protections to the point where only a few women would be able to realize its promise of legal reproductive autonomy—are readily apparent. The conduct of hundreds of thousands of otherwise law-abiding citizens would be criminalized, leading to widespread disobedience, undermining the effectiveness of the criminal justice system, and promoting a more general disrespect for the law.

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[54] Monaghan, *supra* n.11, at 751.

[55] *Id.* at 758-60. *See also Swift & Co.* v. *Wickham*, 382 U.S. 111, 116 (1965) (Court will reconsider precedent in light of its "mischievous consequences"); *Canada Packers, Ltd.* v. *Atchison, T. & S.F. Ry.*, 385 U.S. at 184 (Court will not reconsider precedent that has not "produced any particularly unfortunate consequences").

"Those without * * * adequate resources" [56] would suffer most, as they would be forced by circumstance to turn to dangerous and illegal abortions,[57] or to sacrifice altogether their right of reproductive freedom.[58] Similarly, regulatory restrictions on access to abortion would have the practical effect of withdrawing the right recognized in *Roe* from millions of poor and rural women.[59] For all women, medically unnecessary restrictions would inevitably tend to delay abortions to a later point in pregnancy when the procedure is more complicated and dangerous. It is ironic indeed that states could subject women to an enforced reproductive code at great cost to their well-being, while attempting to justify those restrictions "under the guise of protecting maternal health." [60] Thus, the adverse health consequences alone demand continued

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[56] *Griswold*, 381 U.S. at 503 (White, J., concurring).

[57] Legal abortions are significantly safer than illegal ones. *See, e.g.*, Cates & Rochat, *Illegal Abortions in the United States: 1972-74*, 8 Fam. Plann. Persp. 86 (1976); R. Schwartz, *Septic Abortion* (1968); Cates, *Legal Abortion: The Public Health Record*, 215 Science 1586 (1982).

[58] Such a sacrifice would not only substantially narrow women's freedom to plan their lives, it would subject them to additional health risks, since legal abortion is medically safer than childbirth. *See* C. Teitze & S. Henshaw, *Induced Abortion: A World Review* 110 (1986).

[59] For example, almost 80% of rural Americans live in counties with no abortion services. *See* Henshaw, Forrest & Van Vort, *Abortion Services in the United States 1984 and 1985*, 19 Fam. Plann. Persp. 63, 64-65 (1987). The prospect of a long journey to a facility meeting requirements such as those at issue in this case—or, indeed, being forced to undertake such a trip *twice* to satisfy waiting period requirements—would predictably preclude many pregnant women from seeking abortion services. *See Akron*, 462 U.S. at 434-435 (hospitalization requirement "may force women to travel to find available facilities, resulting in both financial expense and additional health risk * * * [and therefore] may significantly limit a woman's ability to obtain an abortion").

[60] *Thornburgh*, 476 U.S. at 759.

respect for *Roe* under the Court's *stare decisis* precedents.[61]

Moreover, the regulation of abortion is peculiarly unsuited to a multiplicity of inconsistent state laws. The conflicting regulation that would result from subjecting this fundamental right to the raw political process would not, as a practical matter, advance any cognizable federalism concern, but would only lead to an interstate traffic of women seeking to terminate their pregnancies under conditions of safety.[62] The simple fact is that coercive abortion laws are unenforceable against the state's more affluent citizens and have as a foreseeable consequence the creation of hundreds of thousands of crim-

[61] The imposition of restrictions on the bases for which women may seek to terminate a pregnancy would inevitably lead to establishment of enforcement mechanisms that make every woman submit herself to those who were empowered to ascertain whether her reasons for not continuing a pregnancy met with official state approval. Even where a state might "approve" a woman's decision, the very process of subjecting her decision to state review could impose an unacceptable barrier to the exercise of her rights. A rape victim's right to abort, for example, is by no means fully protected by a statute that restricts abortion generally but makes an exception permitting abortion for pregnancy by rape. A rape victim is in a far worse position under such a statute than she is under *Roe* v. *Wade*. Under *Roe*, a woman who has been raped can simply choose to abort a pregnancy. If *Roe* is overturned, and a rape victim must rely on a "rape exception" in a state statute, she will not have the right to choose abortion, but only the quite different "right" to seek to *prove* to some governmental officials that she was "in fact" raped, often a difficult and traumatic task. Proving rape would not be the only difficulty she would encounter. To come within an exception for pregnancy by rape, a woman also could be required to prove that the pregnancy she is seeking to terminate actually *resulted from* the rape and not from some other act of sexual intercourse. For all women, choice could be replaced by cross-examination.

[62] Some states or localities might attempt to make it a crime for women to travel in order to seek an abortion, but such laws would be virtually unenforceable in a nation of open interstate borders.

inals out of otherwise law-abiding citizens. Travel to other states would become widespread among those able to afford it, while the "marginal reduction in abortions will come from among the very poor who are unable to afford transportation to states where the practice is permitted." [63] There will not be separate policies on abortion for women living in different states as much as there will be separate policies for women of different social and economic status.

Congress has a legitimate concern that a patchwork of conflicting state abortion laws will both produce friction among states and increase the burdens of an already overburdened health care system. States that continue to permit women to choose safe and legal termination of pregnancy will face an enormously increased burden on their health care systems from women residing in states with more restrictive laws.[64] At the same time, health care facilities in those states and localities that curtail access to safe and legal abortions will face a substantial increase in the number of women experiencing serious medical complications as a result of illegal self-induced or back-alley abortions. Those women who are unable to travel elsewhere will be returned to a dismal pre-*Roe* era: whiskey as an anesthetic; doctors who were sometimes marginal or unlicensed practitioners, sometimes

[63] Kaplan, *Abortion as a Vice Crime: A "What If" Story*, 51 Law & Contemp. Probs. 151, 159 (1988).

[64] In the two years following New York's decision to permit licensed physicians to provide pregnancy termination services to women less than 24 weeks pregnant, 65.7% of the approximately 400,000 abortions performed in New York City were performed on nonresidents. Patker, O'Hare, Neilson & Suigir, *Two Years' Experience in New York City with the Liberalized Abortion Law—Progress and Problems*, 63 Am. J. Pub. Health 524 (1973). A return to that regime, in an era in which metropolitan hospitals, already overwhelmed with AIDS cases, would carry the burden of providing abortions to women from other states, would be a disaster.

alcoholic, sometimes sexually abusive; unsanitary conditions; incompetent treatment; infection, hemorrhage, disfigurement and even death. In the year before *Roe* v. *Wade*, women having unlawful abortions were eight times more likely to die from the procedure than women having lawful abortions.[65]

As members of Congress, we believe that the Court must take into account real-world consequences such as these rather than imposing such heavy burdens on those least able to bear them. Whether one favors or opposes abortion as a matter of personal conscience, it is difficult to conclude that subjecting this highly personal and fundamentally important liberty to a political process and hodgepodge of inconsistent state laws would advance any meaningful public goal or avoid any "particularly unfortunate consequences."

Finally, overruling *Roe* would represent an unprecedented withdrawal by the Court of a fundamental right that has assumed profound significance in the lives of millions of women. While the Court has declined to recognize new constitutional rights and has overruled cases involving marginal expansions of certain rights, it has never taken away an established right of such central importance to basic life choices as *Roe*'s right of reproductive autonomy.[66] *Roe* promises women the freedom to plan their lives and to make the most intimate choices

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[65] Cates & Rochat, *supra* n.57, at 91-92. As a consequence of *Roe* v. *Wade*, abortion deaths dropped sharply. *Id.* at 87.

[66] Even a simple description of cases in which rights have been circumscribed is sufficient to show that they are in no way comparable to *Roe*. *See Hudgens* v. *NLRB*, 424 U.S. 507 (1976), *overruling Amalgamated Food Employees Union* v. *Logan Valley Plaza, Inc.*, 391 U.S. 308 (1968) (private shopping malls not equivalent to "company towns" for purposes of First Amendment protections); *Miller* v. *California*, 413 U.S. 15 (1973), *overruling Memoirs* v. *Massachusetts*, 383 U.S. 413 (1966) (modifying test for obscenity).

free of state compulsion.[67] Since *Roe* was decided, millions of women have ordered their lives in reliance on this promise and "'on the expected stability of the decision.'"[68] Overruling *Roe* would frustrate these settled expectations and thereby call into question the legitimacy of our governmental institutions and the rule of law.

CONCLUSION

For the foregoing reasons, we urge that the continuing validity of *Roe* v. *Wade* be reaffirmed and that the judgment below be upheld.

Respectfully submitted,

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October 1989

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[67] With that freedom comes a moral obligation to take responsibility for the choices that are made. Arguments for restrictions on abortion frequently reflect, implicitly or explicitly, the view that women are not fully capable of making ethical decisions. Such a stereotyped assumption, which is closely related to this country's "long and unfortunate history of sex discrimination" (*Frontiero* v. *Richardson*, 411 U.S. 677, 684 (1973) (plurality op.)), no longer has a place in this Court's jurisprudence or in any of our nation's laws.

[68] *Monell* v. *Department of Social Services*, 436 U.S. at 700 (quoting *Monroe* v. *Pape*, 365 U.S. 167, 222 (1961) (Frankfurter, J., dissenting)).

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AMICUS CURIAE

BRIEF

No. 88-790

(26)

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In The

Supreme Court of the United States

October Term, 1989

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, *et al.*,

Appellants,

vs.

RICHARD M. RAGSDALE, M.D., *et al.*,

Appellees.

On Appeal From The United States Court Of Appeals For The Seventh Circuit

BRIEF OF THE ATTORNEYS GENERAL OF THE STATES OF ALASKA, CALIFORNIA, COLORADO, MASSACHUSETTS, NEW YORK, TEXAS AND VERMONT AS *AMICI CURIAE* IN SUPPORT OF APPELLEES

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TABLE OF CONTENTS

Page

INTEREST OF *AMICI CURIAE* 1

SUMMARY OF ARGUMENT 2

ARGUMENT 4

I. *ROE* v. *WADE* SHOULD BE REAFFIRMED 4

II. THE STATUTES AT ISSUE IMPERMISSIBLY INFRINGE ON THE ABORTION DECISION 8

III. A RETREAT FROM *ROE* v. *WADE* WOULD JEOPARDIZE THE PUBLIC HEALTH, SAFETY AND WELFARE AND PLACE INCREASED BURDENS ON STATE LAW ENFORCEMENT. 15

A. If States Are Permitted to Enact Very Restrictive Abortion Laws, the Health Consequences Will Be Severe, Even in States Where it Remains Available 16

B. An Increased Burden on Regulatory Agencies and Law Enforcement Will Result 21

C. The Burden On Law Enforcement Will Also Increase Where Abortion is Severely Restricted 24

CONCLUSION 28

TABLE OF AUTHORITIES

Page

CASES

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Baird v. *Dept. of Pub. Health*, 599 F.2d 1098 (1st Cir. 1979).....7, 8

Bellotti v. *Baird*, 443 U.S. 622 (1979) 14

Bering v. *Share*, 106 Wash.2d 212, 721 P.2d 918 (1986), *cert. denied*, 479 U.S. 1050 (1987)..... 24

Carey v. *Population Services International*, 431 U.S. 678 (1977).....13, 14

City of Akron v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983).... 4, 6, 9, 12, 14, 20

Clinic for Women, Inc. v. *Citizens for Life*, No. C83-2651 (Cir. Ct. Indiana, Marion Cty., Aug. 31, 1984) 24

Connecticut v. *Menillo*, 423 U.S. 9 (1975) 5

Doe v. *Bolton*, 410 U.S. 179 (1973) ... 4, 6, 12, 14, 19, 20

Fargo Women's Health Org., Inc. v. *Larson*, 381 N.W.2d 176 (N.D.), *aff'd*, 391 N.W.2d 627 (N.D.), *cert. denied*, 476 U.S. 1108 (1986) 23

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H.L. v. *Matheson*, 450 U.S. 398 (1981)..... 7

Harris v. *McRae*, 448 U.S. 297 (1980)..... 19

Kugler v. *Ryan*, 682 S.W.2d 47 (Mo. App. 1984)..... 24

Maher v. *Roe*, 432 U.S. 464 (1977)..... 7, 8, 13, 14

TABLE OF AUTHORITIES – Continued

Page

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Planned Parenthood Association, Inc. v. *Ashcroft*, 462 U.S. 476 (1983) 5, 7, 9

Planned Parenthood of Central Missouri v. *Danforth*, 428 U.S. 52 (1976) 4, 5, 6, 14

Ragsdale v. *Turnock*, 841 F.2d 1358 (7th Cir. 1988) 13

Ragsdale v. *Turnock*, 625 F.Supp. 1212 (N.D. Ill. 1985).....9, 13

Roe v. *Wade*, 410 U.S. 113 (1973) ..... *passim*

Sendak v. *Arnold*, 429 U.S. 968 (1976) 11

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Page

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Ward v. *Rock Against Racism*, ___ U.S. ___, 109 S.Ct. 2746 (1989)..... 10

Webster v. *Reproductive Health Services*, ___ U.S. ___, 109 S.Ct. 3040 (1989) 7, 14

Westchester Women's Health Org. v. *Whalen*, 475 F.Supp. 734 (S.D.N.Y. 1979) 7, 8

Williams v. *Zbaraz*, 448 U.S. 358 (1980) 10

STATUTES

111 Ill. Rev. Stat., ¶ 4400-22 (1) (Medical Practice Act)..... 9

111 ½ Ill. Rev. Stat., ¶ 157-8.3 (ASTC Act)..... 10

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INTEREST OF *AMICI CURIAE*

The Attorneys General of Alaska, California, Colorado, Massachusetts, New York and Texas submit this brief *amici curiae* in support of appellees Richard M. Ragsdale, *et al.* They respond to appellants Bernard J. Turnock, *et al.*, who in effect request this Court to reinterpret or overrule *Roe v. Wade*, 410 U.S. 113 (1973) as it applies to first and early second trimester abortions. *Amici* Attorneys General urge this Court to retain the holding of *Roe* that a woman has a fundamental right to decide whether to terminate her pregnancy, to retain *Roe's* establishment of a trimester framework within which to scrutinize regulations, and to affirm the holding below that the statutes at issue are not justified by the State's compelling interest in maternal health.

As chief law enforcement officers of their respective States, and as representatives of state government, *amici* are charged with a number of duties and responsibilities which bear on the question presented. These include: (1) protecting the fundamental individual rights and liberties of the people of their State under the federal and state constitutions; (2) protecting the State's sovereign interests and role in our constitutional system; (3) protecting the health, safety and well-being of the people of their State; (4) enforcing state criminal and civil laws, including those that may regulate abortion; (5) enforcing state regulatory schemes involving health care and consumer protection; and (6) advising other branches of state government on the legality of state regulation of abortion, and defending any such regulation under *Roe* and its progeny.

Amici have a strong interest in the stability and consistency of the law. Stability and consistency ensure that issues will not endlessly be relitigated and infuse citizens with the confidence that laws will be interpreted fairly, uniformly and objectively.

Amici also have a fundamental interest in protecting the most basic tenets of our constitutional form of government, namely the reservation of certain powers and rights to the individual free from infringement by either the state or national government, the allocation of powers not so reserved between the states and national government and the separation of powers among branches of government. As the chief law enforcement officers of their respective states, *amici* are particularly sensitive to the proper role of government and law enforcement and the dangers of excessive government intrusion.

Because of their roles and responsibilities, *amici* believe they are compelled, and uniquely qualified, to address the questions presented.

SUMMARY OF ARGUMENT

In *Roe v. Wade*, 410 U.S. 113, this Court held that a woman's decision whether to bear a child or terminate a pregnancy is encompassed in the fundamental constitutional right of privacy. This right, while not absolute, may be regulated by the State only to further its compelling interest in protecting maternal health or, after viability, in protecting potential life. Under *Roe* and its progeny, statutes regulating abortion properly have been strictly scrutinized by the Courts in order to determine whether they

in fact serve one of these compelling interests, and are narrowly tailored to serve only those interests.

Because at the time *Roe* was decided, abortion in the first trimester of pregnancy was as safe or safer than childbirth, the Court found that the woman's right to decide during that period whether to terminate her pregnancy should be made essentially free of government interference. This principle has been interpreted in subsequent cases to allow regulations which have a *de minimis* burden on abortion, so long as they are designed to support the underlying premise of *Roe* that first trimester abortion is a safer procedure than childbirth.

The laws herein cannot suvive scrutiny under *Roe* because they serve no ascertainable health interest. They limit the kinds of facilities in which first trimester abortions may be performed, preventing doctors from performing the procedure in their offices. They impose onerous and medically unnecessary requirements on those facilities, including detailed architectural, design and staffing requirements. Moreover, they require additional, abortion-specific requirements such as a second pregnancy test.

For the Court to apply either the more deferential "rational basis" or "undue burden" test to statutes which adversely impact on the abortion decision, especially in the first trimester, would amount to a reversal of *Roe v. Wade*. Permitting States to impose requirements that increase the cost of early abortions and restrict their availability without requiring them to justify such burdens as in fact furthering the State's interest in maternal health would significantly jeopardize the public health

and welfare. Experience shows that even when access to abortion is severely restricted or banned, many women with unwanted pregnancies are willing to take great risks to end them. Laws restricting access to abortion will thus adversely affect women's health, place great strains on state health care systems, undermine respect for the law and hamper law enforcement efforts.

ARGUMENT

I. *ROE v. WADE* SHOULD BE REAFFIRMED.

In its landmark decision in *Roe v. Wade*, 410 U.S. 113, this Court held that the constitutional right of privacy is broad enough to encompass a woman's decision whether or not to terminate a pregnancy. 410 U.S. at 153. *Roe* also held that this right, while fundamental, is not absolute, and may be regulated by the State, but only to further its interest in protecting maternal health, *id.* at 150, and, after viability, its interest in protecting potential life. *Id.* at 162.

Under *Roe* and its progeny, courts have strictly scrutinized statutes regulating abortion to determine whether in fact they serve one of these two compelling interests, and, if so, whether they are narrowly tailored to serve only those interests. *E.g., Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 759 (1986) (*"Thornburgh"*); *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 426-427 (1983) (*"Akron"*); *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976) (*"Danforth"*); *Doe v. Bolton*, 410 U.S. 199 (1973).

During the first trimester, courts have permitted only regulations which impose a minimal burden on the decision to terminate a pregnancy. Abortion in the first trimester is a relatively safe, simple procedure entailing far fewer health risks to the woman than carrying the pregnancy to term and giving birth. *Roe v. Wade*, 410 U.S. at 163; *Akron*, 462 U.S. at 430-431.[1] Therefore, the range within which regulations *in fact* further the State's interests in maternal health is narrow, and is limited to those necessary to ensure that *Roe*'s premise remains intact, that is, that first trimester abortion remains a safe procedure. *Akron*, 462 U.S. at 436-438.

For example, this Court has upheld a requirement that all abortions be performed by a licensed physician. *Connecticut v. Menillo*, 423 U.S. 9 (1975) (*per curiam*). A statute mandating written consent and a recordkeeping requirement were upheld in *Danforth*, 428 U.S. 52. A requirement that tissues removed by abortion, like all other removed tissues, be examined by a pathologist, was upheld in *Planned Parenthood Association, Inc. v. Ashcroft*, 462 U.S. 476 (1983) (*"Ashcroft"*). In each of these cases, the regulation was in accordance with generally accepted medical practice and did not impose more than a *de minimis* burden on the abortion right.[2]

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[1] Even including later abortions, the mortality rate for childbirth is seventeen times the mortality rate for abortion. Grimes, *Second Trimester Abortions in the United States*, 16 Fam. Plan. Persp. 260, 262 (Nov./Dec. 1984).

[2] In contrast, regulations requiring that first trimester abortions be performed in hospitals or hospital-like settings are not medically appropriate, would not increase their safety

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In the second trimester, because abortion may entail increased risks to the woman, the State's interests in protecting maternal health become compelling, and may justify more extensive regulations than in the first trimester. However, to the extent that such regulations impose a burden on the decision to have an abortion, they must be examined to see whether they in fact serve such interests and are narrowly tailored to serve only those interests. *Thornburgh*, 476 U.S. at 759; *Akron*, 462 U.S. at 434.

The framework announced in *Roe* and adhered to in subsequent decisions has proven to be a workable and fair standard that allows States to vindicate their compelling interests in promoting public health and protecting viable life while not infringing the woman's privacy right.[3] The trimester framework did not dictate the differing levels of permissible state regulation in *Roe*. Rather, it

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and would not in fact further important state health objectives. *Akron*, 462 U.S. at 433-437. This Court has also struck down such similarly onerous requirements as advance approval by a hospital committee and concurrence by two additional doctors, *Doe v. Bolton*, 410 U.S. at 197-200, spousal consent, *Danforth*, 428 U.S. at 68-70, waiting periods, *Akron*, 462 U.S. at 450-451, and intrusive recordkeeping, *Thornburgh*, 476 U.S. at 765-767.

[3] Illinois has never claimed that these statutes were justified by the State's interest in protecting potential life. In any event, under *Roe* that interest, though *present* throughout pregnancy, is not *compelling* until viability. Before viability the fetus is not a biological entity separate and distinct from its mother. Rather, it is entirely dependent on one single person, its mother, to sustain the conditions that make its future development possible. *See* Law, *Rethinking Sex and the Constitution*, 132 U. Pa. L. Rev. 955, 1023-1024, 1027 (1984), noting that at least

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is a recognition that as the fetus develops, the risks inherent in the procedure increase and the "separateness" of the fetus increases. Far from creating a "Procrustean bed," *Webster v. Reproductive Health Services*, ___U.S ___, [109 S.Ct 3040, 3056] (1989) ("*Webster*"), *Roe* and its progeny have allowed States reasonable room to maneuver in regulating abortion. States have considerable latitude in regulating the expenditure of public funds for abortion, *Webster*, 109 S.Ct. at 3052, *Maher v. Roe*, 432 U.S. 464 (1977), and in regulating abortion after the threshold of viability. *Webster*; *Ashcroft*, 462 U.S. at 482-486; *Roe*, 410 U.S. at 163-164. States may also impose some regulations on abortion facilities, *Akron*, 462 U.S. at 433-434; *Baird v. Department of Public Health*, 599 F.2d 1098, 1101-1102 (1st Cir. 1979); *Westchester Women's Health Org. v. Whalen*, 475 F.Supp. 734 (S.D.N.Y. 1979), and may require some forms of parental involvement. *H.L. v. Matheson*, 450 U.S. 398, 409-410 (1981).

Amici urge that the *Roe* framework be retained. To permit a State to regulate early abortion without justifying its regulation under strict scrutiny as actually necessary to protect maternal health, and without positing a countervailing, fundamental right in the woman, would leave the States free to regulate in a manner that is not only medically inappropriate, but which subordinates the

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pre-viability, it is not society but one particular woman who is able to provide the sustenance the fetus needs. The State's interest in fetal life can only be asserted at the expense of the woman's ability to decide whether she is able to sustain this relationship with its attendant costs, responsibilities and risks.

living female person to the potential life within her. Such a holding would indeed remove the "constitutional protection against state interference with certain aspects of an individual's personal 'privacy', including a woman's decision to terminate her pregnancy," *Maher v. Roe*, 432 U.S. at 471-472, thus reversing sixteen years of settled constitutional doctrine.

II. THE STATUTES AT ISSUE IMPERMISSIBLY INFRINGE ON THE ABORTION DECISION.

While *amici* concur that some regulation of outpatient clinics is appropriate,[4] the statutes herein must fail under *Roe* and its progeny because they impose substantial burdens on the abortion right, and have not been shown to serve any valid state interest in protecting maternal health.

As originally enacted, the Illinois scheme (1) required that a doctor perform abortions only in an Ambulatory Surgical Treatment Center ("ASTC") or in an accredited hospital or state or federal government facility, or risk a license revocation; (2) required that all facilities devoted primarily to the performance of surgical procedures *or* in which pregnancy terminations were performed be licensed as ASTCs; (3) imposed strict design, staffing and other criteria on ASTCs, including some abortion-specific regulations; and (4) required all second trimester abortions to be performed in a hospital. In effect, the scheme

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[4] *See, e.g., Baird v. Department of Public Health*, 599 F.2d 1098, 1101-1102 (1st Cir. 1979); *Westchester Women's Health Org. v. Whalen*, 475 F.Supp. 734 (S.D.N.Y. 1979).

precluded doctors from performing first trimester abortions in their offices or in clinics which did not meet the requirements for an ASTC license.[5] The statutes were not intended to be abortion-neutral.[6] In any event, even if

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[5] At the time the district court granted the preliminary injunction from which this appeal was taken, because of numerous intervening court decisions, various parts of the scheme were not being enforced. The second trimester hospital requirement was no longer enforced, in view of this Court's decision striking down such a requirement in *Akron*, 462 U.S. 416, and *Ashcroft*, 462 U.S. 476. The ASTC licensing requirement was applied only to facilities devoted primarily to the performance of surgery, including pregnancy terminations, based on a decision of the Illinois Supreme Court in *Village of Oak Lawn v. Marcowitz*, 86 Ill.2d 406, 427 N.E.2d 36 (1981), which in essence held that abortion could not be singled out from other surgical procedures and subjected to stricter licensing requirements. The State claimed that it was not enforcing the medical licensing requirements, although the evidence indicated that it had never so informed physicians or abortion providers. *Ragsdale v. Turnock*, 625 F.Supp. 1212, 1228 (N.D. Ill. 1985). However, as the court of appeals stated, the loss of a professional license is a sufficiently severe sanction, and the State's evidence that the law was not being enforced was sufficiently ambiguous, that the validity of Section 16(1) of the Medical Practice Act, 111 Ill. Rev. Stat. ¶ 4400-22(1), should not be considered moot. *Ragsdale v. Turnock*, 841 F.2d 1358, 1366 (7th Cir. 1988). Even the dissenting court of appeals justice would have struck Section 16(1). *Ragsdale v. Turnock, Id.* at 1378-1379 (Coffey, J. dissenting.)

[6] Both the abortion-related section of the Medical Practice Act and the ASTC Act were originally companion bills to the restrictive Illinois Abortion Act. *Ragsdale v. Turnock*, 841 F.2d at 1378. Abortion is the only medical procedure which is specifically mentioned in the licensing statute. 111 Ill. Rev. Stat. ¶ 4400-22(1) (Jur. App. 193). Abortion alone was mentioned in the definition of "Ambulatory Surgical Treatment Center," and

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they were abortion-neutral, they would still be subject to strict scrutiny under *Roe* because of their impact on the abortion decision.[7]

This complex regulatory scheme was enacted by a state legislature which had already voted to ban public funding for abortion. *Williams v. Zbaraz*, 448 U.S. 358 (1980). By extensively regulating private clinics of the kind in which the vast majority of abortions are performed and, at the same time, eliminating public funding for abortion, Illinois has done more than make a value

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although the Act was made applicable to facilities "primarily devoted" to the performance of other surgical procedures, it was made applicable to *any* facility performing pregnancy terminations. 111 1/2 Ill. Rev. Stat., ¶ 157-8.3 (Jur. App. 149-150). The ASTC regulations similarly contained many abortion-specific provisions. The penalties for violations of these statutes are severe. Persons operating an ASTC without the proper license are subject to a fine of up to $ 10,000 per day, and up to $ 10,000 for any other violation of the Act. 111 1/2 Ill. Rev. Stat., ¶ 157-8.12 (Jur. App. 163). Doctors performing abortions in an unapproved facility are subject to loss of their license to practice medicine.

[7] In other situations involving protected interests, the Court has required that even content-neutral regulations be "narrowly tailored to serve a significant governmental interest" and not create a substantial or material deleterious effect on the exercise of the protected activity. *Ward v. Rock Against Racism*, ___U.S.___, [109 S.Ct 2746, 2753, 2759-2760] (1989).

judgment favoring childbirth over abortion; it has affirmatively placed abortion beyond the reach of many women.[8]

Extensive regulation of clinics increases the cost of abortions and reduces their availability, because many providers who would be able safely to perform first trimester and early second trimester abortions in their facilities are unwilling or unable to incur the added expense of meeting the ASTC requirements.[9] According to appellants, at the time of the preliminary injunction hearing there were only 22 licensed ASTCs which offered

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[8] For women of limited means seeking abortion, clinics of the sort operated by Dr. Ragsdale offer lower cost services. Henshaw, Forrest and Van Vort, *Abortion Services in the United States, 1984-1985*, 19 Fam. Plan. Persp. 63, 69 (Mar./Apr. 1987) [hereinafter Henshaw, Forrest & Van Vort]. Typically such clinics provide 60 percent of all abortions, and, if clinics whose primary practice is not pregnancy terminations are included, 83 percent of all abortions. *Id.* at 67. Thirteen percent of abortions are performed in hospitals; of these, 66 percent are performed as outpatient procedures. Only three percent involve actual hospitalization. *Ibid.* Only four percent of all abortions nationwide are performed in doctors' offices.

[9] Even though abortions may remain available to some women through individual doctors, either because they are willing to run the risk of testing the State's enforcement policy, or because of lax enforcement, women of limited means are less likely to have a personal physician to whom to turn for such a procedure. Furthermore, more than 20 times as many abortions are typically performed in clinics as in doctors' offices. For most women the alternative is largely illusory. *Cf. Sendak v. Arnold*, 429 U.S. 968 (1976).

abortion services in the entire State of Illinois (Brief of Appellant at 8), a State in which there are approximately 65,000 abortions performed annually.[10]

There is no serious question as to the effect of these restrictions – women will be delayed in effectuating their decision to terminate a pregnancy, and, in some cases, prevented from obtaining abortions altogether. Regulations which cause such delays, with no medical justification, have repeatedly been held to impermissibly infringe on the abortion decision.[11]

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[10] Henshaw, Forrest and Van Vort, *supra* note 8, at 65.

[11] *Thornburgh*, 476 U.S. at 771; *Akron*, 462 U.S. at 450-451; *Bellotti v. Baird*, 443 U.S. 622, 644 (1979); *Doe v. Bolton*, 410 U.S. at 198; *Monmouth Co. Corr. Inst. Inmates v. Lanzaro*, 834 F.2d 326, 339 (3rd. Cir. 1987) *cert. denied*, ___U.S.___, [108 S.Ct. 1731] (1988); *New York State National Org. of Women v. Terry*, 704 F.Supp. 1247, 1261-1262 (S.D.N.Y. 1989). To the extent that these regulations create an absolute obstacle to the effectuation of a decision to terminate a pregnancy, or a significant delay in carrying out that decision, *see, e.g.*, Torres and Forrest, *Why Do Women Have Abortions?* 20 Fam. Plan. Persp. 167, 175 (July/Aug. 1988) [hereinafter Torres & Forrest], they actually expose a woman to greater hazards. Abortion is safer the earlier in the pregnancy it is performed. After eight weeks the risk of major complications rises substantially with each passing week. The risk of mortality, though low, also rises. Any delay, particularly after the eighth week, must therefore be considered potentially threatening to the woman. Kafrissen, Binkin, Grimes and Cates, *Abortion: Incidence, Mortality, and Morbidity*, in Perspectives on Abortion (Sachdev ed.) at 136-137 (1985). It therefore disserves the interest in maternal health for the State to obstruct the abortion decision in any significant way.

The trial court below held that the State had failed to demonstrate, *or indeed to present any evidence*, that the statutes and regulations were medically necessary. *Ragsdale v. Turnock*, 625 F.Supp. 1212, 1230 (N.D. Ill. 1985). In fact, the district court noted that the State had failed to demonstrate even a rational basis for most of the regulations. *Ibid.*[12]

Thus, under the strict scrutiny test, these regulations cannot be justified by the State's interest in maternal health because they do not in fact serve to further that interest and will in fact have a deleterious effect on the public health by increasing the cost of abortions and causing delays in obtaining the procedure.

Appellants assert that even under the strict scrutiny test, the statutes are constitutionally valid because they do not "unduly burden" the decision to terminate a pregnancy. (Brief of Appellants at 40.) Appellants cite *Carey v. Population Services International*, 431 U.S. 678, 685-686 (1977) and *Maher v. Roe*, 432 U.S. at 473-474 for the

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[12] The State's medical witness, while testifying that there was a medical necessity for some regulation of outpatient abortion facilities, "did not testify as to the medical necessity of any of the statutes or regulations here challenged." *Ragsdale v. Turnock*, 625 F.Supp. at 1230. The only witness who testified that the architectural requirements might be advisable was under the erroneous impression that early abortions required an incision. *Ragsdale v. Turnock*, 841 F.2d at 1374. He testified that these requirements were designed with procedures involving general anesthesia in mind, although first and early second trimester abortions are not performed with general anesthesia. *Ibid.*

proposition that only those statutes which impose an "undue burden" are unconstitutional. But the determination whether a burden is undue is arrived at after it has been determined whether a regulation actually serves a compelling state interest and whether it is sufficiently narrowly tailored. To the extent that appellants suggest otherwise, they have misstated the test. *Carey*, 431 U.S. at 685-686. Cf. *Akron*, 462 U.S. at 434.

In *Maher* itself the Court did not apply the strict scrutiny test because it found the interest in question, the right to a *state funded* abortion, not to be fundamental. 432 U.S. at 473-474. *Accord, Webster v. Reproductive Health Services*, 109 S.Ct 3040.[13]

Only under the most deferential rational basis test could these statutes be considered constitutional.[14] *Amici* believe such a standard would be wholly inappropriate

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[13] However, the cases cited in *Maher* did apply the strict scrutiny test. *Carey*, 431 U.S. at 685-686; *Danforth*, 428 U.S. at 76; *Doe v. Bolton*, 410 U.S. at 189, 198-199. *Bellotti v. Baird* simply paraphrased *Carey*. 428 U.S. at 149-150. Were this Court to adopt the "unduly burdensome" standard, as articulated by Justice O'Connor in her dissenting opinions in *Akron*, 462 U.S. at 452-466 and *Thornburgh*, 476 U.S. at 828-833, the regulations at issue would still be invalid, as they have been shown to amount to an absolute obstacle for many women seeking abortions. *Amici* would urge the Court not to adopt this standard, however. Such a test is inherently subjective, necessitating judicial value judgments about whether particular burdens are "undue." While the *Roe* standard has proven workable, a new test would only increase, not reduce, litigation and controversy.

[14] The regulations do not survive even this standard, as the district court found. *See supra* note 12.

for statutes that so directly and adversely affect a woman's right to reproductive choice. If there is to be no real scrutiny by the federal courts of whether the State's health interests are truly served by any particular regulation, a State would be permitted to impose regulations that would double, triple or quadruple the cost of an abortion, until it had priced the procedure out of reach of most of the women who choose that alternative. It would further be permitted to impose requirements on clinics and providers which are not medically necessary and which serve only to create obstacles to the effectuation of a woman's choice to terminate a pregnancy in its early stages. To permit States to impose such obstacles would in effect mean a return to the pre-*Roe* days when only the wealthy, well-connected and well-organized could obtain abortions.

III. A RETREAT FROM *ROE v. WADE* WOULD JEOPARDIZE THE PUBLIC HEALTH, SAFETY AND WELFARE AND PLACE INCREASED BURDENS ON STATE LAW ENFORCEMENT.

Countless individuals have relied upon the rights secured by *Roe v. Wade* and its progeny in ordering their affairs and lives. The liberalization of abortion laws has brought out of the shadows what was once a furtive and dangerous procedure, making it possible for women to exercise procreative choice safely, with minimal danger to their lives and health. Experience teaches that women who want abortions will not be deterred by restrictive laws. If individual States are permitted to impose restrictions on abortion which are unrelated to legitimate interests in

maternal health, a patchwork of laws will result.[15] Those States which continue to allow women to choose abortion with few restrictions will incur a disproportionate burden as other States severely restrict its availability. Law enforcement officers such as the *amici* Attorneys General will be faced with enforcing virtually unenforceable laws, necessitating a diversion of scarce law enforcement resources.

A. If States Are Permitted to Enact Very Restrictive Abortion Laws, the Health Consequences Will Be Severe, Even in States Where it Remains Available.

If States are permitted to severely restrict the availability of abortion through the imposition of onerous restrictions, women living in those States will not cease to obtain or attempt to obtain abortions; rather they will find ways to circumvent restrictive laws, thereby endangering their health and safety.[16] Abortion-related deaths,

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[15] *See* J. Legge, *Abortion Policy: An Evaluation of the Consequences for Maternal and Infant Health* 118-19, Table 7.1 (1985) [hereinafter Legge] (describing eight types of pre-*Roe* abortion laws). In addition, post-*Roe* state court decisions may impose state constitutional requirements on abortion. *See, e.g., Moe v. Sec'y of Admin. & Fin.*, 382 Mass. 629, 417 N.E.2d 387 (1981) (woman has right under due process clause of Massachusetts constitution to choose to terminate her pregnancy).

[16] The immediate effect of legalization was not to significantly increase the numbers of women obtaining abortions, but rather to guarantee that the number of abortions previously clandestinely obtained, were instead obtained under safe, legal medical conditions. *See* Alan Guttmacher Institute, *Safe and Legal: 10 Years' Experience With Legal Abortion in New York State* 17, 23 (S. Henshaw, J. Van Vort, eds. 1980) [hereinafter Guttmacher]. Nationwide, an estimated one million illegal abortions were performed annually in the years before *Roe*, two-thirds of which were on married women. *See* The President's

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injuries and illnesses will increase,[17] particularly among poor and minority women.[18]

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Comm'n on Law Enforcement & Admin. of Justice, Task Force Report; The Courts 105 (1967) [hereinafter Task Force Report]; Centers for Disease Control, Morbidity and Mortality Weekly Report, vol. 37, no. 47, "Abortion Surveillance: Preliminary Analysis – United States, 1984, 1985," 713-14 (Nov. 25, 1988), U.S. Dep't of Health and Human Serv./Pub. Health Serv. HHS Pub. No. (CDC) 89-8017 [hereinafter CDC]. The number of abortions performed annually rose to about 1.6 million in 1981 and has remained at this level since. Henshaw, Forrest and Van Vort, *supra* note 10, at 64.

[17] Legalization of abortion significantly reduced abortion-related deaths and illness. Studies in California and New York showed that criminal abortion was the leading cause of maternal deaths, the most common victims married women with several children who attempted to self-abort. H. Ziff, *Recent Abortion Law Reforms (Or Much Ado About Nothing)*, 60 J. Crim. L. and Criminology and Police Sci 3 (1969) [hereinafter Ziff]. After abortion was legalized in New York State, deaths related to abortion declined sharply. Between 1967 and 1969, when abortion was illegal in New York, and 1970-1972, when it was legal, the average annual rate of abortion-related deaths fell by 51 percent. Legalization of abortion in New York State also reduced the number of women admitted for infected, incomplete and spontaneous abortions. *Id.* Similarly, following *Roe*, the number of abortion-related deaths nationwide dropped significantly. By 1982 the number of abortion-related deaths had dropped to 50 percent of those in 1972. Lebolt, Grimes, Cates, *Mortality From Abortion and Childbirth*, 248 J.A.M.A. 188, 191 (July 9, 1982).

[18] Studies during the 1960's in New York and California (before abortion was legal in either state), show that in New

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The adverse health consequences of a retreat from *Roe* would extend to the residents of those States that continue to permit women to freely obtain abortions. As is discussed below, the health-care systems of these States would be burdened by an influx of non-residents seeking to circumvent the restrictive laws in their own States.

States that continue to provide women with the right to choose to terminate their pregnancies can anticipate an influx of non-residents seeking the abortion or related medical services prohibited in their home States. This trend was already evident in 1982, with some areas performing a substantial proportion of abortions on non-residents.[19] Between July 1970, after New York liberalized its abortion law, and June 1972, 65.7% of the approximately 400,000 abortions performed in New York City were performed on non-residents.[20] This number

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York twice as many abortion related fatalities occurred among nonwhites as among whites, while in California low income women were the most frequent abortion fatalities. Ziff, *supra* note 17, at 11. The disparity will be particularly pronounced if States enact restrictions which greatly increase the cost of abortion while allowing it to remain nominally legal.

[19] Henshaw, Forrest and Van Vort, *supra* note 8, at 66.

[20] Patker, O'Hare, Nielson, Suigir, *Two Years' Experience in New York City with the Liberalized Abortion Law-Progress and Problems*, 63 Am. J. Pub. Health 524 (1973) [hereinafter Patker]. Statistics for all of New York State are comparable to those for New York City. According to statistics compiled by the N.Y.S. Department of Health, between 1971 and 1972 a total of approximately 538,000 women obtained abortions, of whom approximately 327,000 – or 60 percent – were non-residents.

dropped precipitously after *Roe*.[21] Because of the widespread acceptance of legal abortion since *Roe* was decided,[22] such trends can be expected to continue if abortion is severely restricted in some States.

Increased numbers of non-resident women seeking abortions or related medical services in States where it remains widely available will strain already overburdened health care systems.[23] Many out-of-state women

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[21] Less than half the number of non-residents who obtained abortions in New York State in 1972 obtained abortions in New York State in 1973. Moreover, between 1974 and 1987, non-residents averaged merely 9.8 percent of the total number of women obtaining abortions in New York State. *Id.*

[22] Nationwide, the number of reported abortions increased from approximately 745,000 in 1973 to 1.58 million in 1981 to 1.6 million in 1985. *See* Alan Guttmacher Institute, *Abortion Services in the United States, Each State and Metropolitan Area, 1984-1985* 16 (S. Henshaw, J. Van Vort, eds. 1988) [hereinafter Guttmacher 1984]; CDC, *supra* note 15. *See also* N.Y. Times, Oct. 6, 1988, § B, at 18, col. 1 (between 1977 and 1987, nearly 3 out of every 100 American women 15 to 44 had an abortion).

[23] This Court has held that a State where abortion is legal may not deny an abortion, or related medical care, to a non-resident. *Doe v. Bolton*, 410 U.S. at 200. During 1970-71, almost 1000 non-residents were treated at New York City hospitals despite hospital residency requirements. Harris, O'Hare, Patker, Nielson, *Legal Abortion 1970-71 – The New York City Experience*, 63 Am. J. Pub. Health 409, 410 (1973). The influx of non-residents could be particularly problematic for a state like Massachusetts where abortion is legal under the state constitution's due process clause, *Moe* v. *Sec'y of Admin. & Fin.*, 382 Mass. 629, 417 N.E. 2d 387, and the state constitution has been interpreted to require public funding, *i.e.*, Medicaid, for abortions. *Compare Harris v. McRae*, 448 U.S. 297 (1980).

will likely seek abortions later in their pregnancies due to their inability to obtain proper counseling in their home States, find a provider or meet the cost of a legal abortion.[24] An increase in the number of late, more complicated, and thus more dangerous abortions will increase the risks to the women themselves and place further strains on these States.[25] States will also have to handle the emergency medical situations posed by injuries and illnesses suffered by women who attempt to self abort or seek the services of illegal abortionists.

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[24] Non-residents obtaining abortions in New York, for example, historically have been more likely to obtain abortions after twelve weeks than New Yorkers. Guttmacher, *supra* note 16, at 19. Inability to locate a provider and make arrangements to obtain an abortion are significant factors leading to delay. Torres & Forrest, *supra* note 11, at 174-175. Delay also escalates costs, thereby resulting in even further delay. Guttmacher, *supra* note 16, at 19; *see also* Henshaw, Forrest, Blaine, *Abortion Services in the United States, 1981-82*, 16 Fam. Plan. Persp. 119, 126 (May/June 1984) (abortion fees are significantly higher for pregnancies past 12 to 14 weeks); Henshaw, Forrest & Van Vort, *supra* note 8, at 63.

[25] *See generally* J. Wilson, R. Carrington, E. Reid, *Obstetrics and Gynecology* 207 (8th ed. 1987); Grimes, *Second Trimester Abortions in the United States*, 16 Fam. Plan. Persp. 260, 263 (Nov./Dec. 1984) (the risk of death from abortions performed at 16 weeks is 24 times greater than from abortions performed at 8 weeks or earlier). Courts have uniformly recognized that "time, of course, is critical in abortion." *Doe v. Bolton*, 410 U.S. at 198; *see, e.g., Akron*, 462 U.S. at 450-51.

B. An Increased Burden on Regulatory Agencies and Law Enforcement Will Result.

If *Roe* is overturned and abortion is severely restricted in some States, it can be anticipated that profiteers in States that permit abortions will exploit the desperation of women seeking abortions or related medical services. Following the adoption of New York's less restrictive abortion law, deceptive referral services multiplied in and out of the State.[26] Unaware of free referral services, including a clergy-run service which operated in twenty States, many women turned to profit-making referral agencies that promised not only referrals to reliable providers at the lowest cost, but transportation services and counseling, as well.[27] None disclosed the excessive portion of the fee the agency retained, or the availability of free referral services.[28]

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[26] *See generally* Edmiston, *Report on the Abortion Capital of the Country: New York City*, N.Y. Times, Apr. 11, 1971 (Magazine), at 11, 37-42 [hereinafter Edmiston]; L. Lader, *Abortion II; Making the Revolution* 164 (1973) [hereinafter Lader]; N.Y. Times, Feb. 10, 1971, at 20, 45, col. 1. The agencies advertised their services in various ways, including billboards, blimps and banners, on Florida beaches, and classified advertisements in local newspapers. Newsweek, July 19, 1971, at 51.

[27] Lader, *supra* note 26, at 164.

[28] A. Morton, *Enemies of Choice: The Right to Life Movement and its Threat to Abortion* 57 (1981) [hereinafter Morton]; N.Y. Times, Feb. 10, 1971, at 45, col. 1; Edmiston, *supra* note 26, at 42.

Not only did the agencies realize exorbitant profits, but they often endangered the health of the women utilizing their services.[29] Personnel at referral agencies without medical training would essentially diagnose the woman – often through a telephone call – and then refer her to a provider, or alternatively, subcontract with a second agency that made the final arrangements with the providers.[30] The provider thus was often not informed of the woman's condition and sometimes was unprepared to assist her.[31] Other women paid large fees to referral agencies only to be told by providers that the price was even greater than the payment already rendered.[32]

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[29] Edmiston, *supra* note 26, at 42.

[30] *Id.* at 38. As a result of a lawsuit brought by New York's Attorney General, the New York courts found that one such agency was illegally engaged in the practice of medicine in violation of the New York Education Law, as well as illegal fee splitting. *State v. Abortion Info. Agency, Inc.*, 69 Misc.2d 825, 829 (Sup.Ct. N.Y. Co. 1971), *aff'd*, 37 A.D.2d 142, 145 (1st Dept. 1971), *aff'd*, 30 N.Y.2d 779, 285 N.E.2d 317 (1972).

[31] Edmiston, *supra* note 26, at 38. For example, a Michigan woman checked into a hospital near Kennedy airport in August of 1971 after payment of $900 to a referral agency advertised in a national magazine. The referral agency subcontracted the referral to a second agency but failed to advise the second agency that the woman required a saline abortion. Uninformed, the doctor performed an unnecessary hysterectomy. *Id.* at 38, 42.

[32] *Id.* at 37, 42 (18 year old from Boston who had traveled to New York forced to sell blood, sleep in parks and beg after provider informed her that abortion would cost $275 more than she had already paid).

Although States which continue to provide access to abortion can enact and enforce laws preventing fraudulent advertising and referral, a retreat from *Roe* would encourage such health-endangering chicanery.[33] In any event, notwithstanding the grave impact such schemes would have on the States that continue to permit abortion, they will have little or no ability to curb deception occurring outside their borders.

Finally, at the same time that a retreat from *Roe* will cause the number of non-resident women seeking abortions in States that continue to permit the procedure to escalate, so too could it trigger an escalation in violent and illegal activity aimed at the clinics in these States that continue to perform abortions. *Amici* welcome peaceful and constitutionally protected expression of diverse views but they fear their States becoming focal points for illegal activities, such as bombings, arson and blockages, that courts in many states have deemed necessary to

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[33] *See, e.g., supra* note 30, (discussing N.Y.S. Attorney General's enforcement of Education Law). It can further be expected that if *Roe* is reversed, states that continue to permit abortion will also experience an increase in deceptive advertising by clinics claiming to perform abortions, but which only provide antiabortion counseling, and do not so specify in their advertisements. *See, e.g., Fargo Women's Health Org., Inc. v. Larson*, 381 N.W.2d 176 (N.D.), *aff'd*, 391 N.W.2d 627 (N.D.), *cert. denied*, 476 U.S. 1108 (1986).

enjoin,[34] that require the expenditure of state funds to control, and that further jeopardize the health and safety of women.[35]

C. *The Burden On Law Enforcement Will Also Increase Where Abortion is Severely Restricted.*

The evidence from the pre-*Roe* period suggests that where access to abortion is severely restricted, substantial

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[34] *See, e.g., New York State Nat'l Org. for Women v. Terry*, 704 F.Supp. 1247 (S.D.N.Y. 1989) (permanently enjoining antiabortion protestors from blockading clinic entrances and awarding $25,000 fines per day for violation of order, in addition to penalties to City of New York for increased costs for failure to notify city in advance of location of demonstration); *Nat'l Abortion Fed'n v. Operation Rescue*, No. 89-1189 AWT (BX)(C.D. Cal. March 15, 1989) (injunction); *Aradia Women's Health Center v. Operation Rescue*, No. C88-1539R (W.D. Wash. Jan. 10, 1989) (preliminary injunction); *Parkmed Co. v. Pro-Life Counseling*, 91 A.D.2d 551, 457 N.Y.S.2d 27 (1st Dept. 1982) (enjoining 11 demonstrators' interference with access to a clinic); *O.B.G.Y.N. Ass'n v. Birthright of Brooklyn & Queens, Inc.*, 64 A.D.2d 894, 407 N.Y.S.2d 903 (2d Dept. 1978); *Bering v. Share*, 106 Wash. 2d 212, 721 P.2d 918 (1986), *cert. denied*, 479 U.S. 1050 (1987)(upholding injunction); *Moyal v. Thompkins*, No. 278465 (Super. Ct. Cal. May 16, 1986) (preliminary injunction against trespass, blocking access, harassment); *Oakland Feminist Women's Health Center v. Thompkins*, No. 276031 (Super. Ct. Cal. Aug. 16, 1985) (preliminary injunction against blocking access and harassment); *Finkel v. Birthright Center*, No. C-3266-83 (Super. Ct. N.J. Aug. 21, 1985); *Kugler v. Ryan*, 682 S.W.2d 47 (Mo. App. 1984); *Clinic for Women, Inc. v. Citizens for Life*, No. C83-2651 (Cir. Ct. Indiana, Marion Cty., Aug. 31, 1984).

[35] Bomb threats, arson attacks and blockades not only threaten the health and safety of clinic personnel and patients, passersby and neighbors, but have made it difficult, if not impossible, for clinics to obtain insurance coverage. *Abortion Clinics Find Insurance Difficult to Obtain*, Am. Bus. News, Feb. 8, 1985, at 20, col. 1; Bus. Ins., Jan. 21, 1985, at 3, col. 2.

numbers of women seek the procedure in other States where it is legal, as discussed above, or procure illegal abortions or attempt the procedure themselves.[36] The latter alternatives resulted in a substantial number of maternal deaths and injuries in the period before *Roe*.[37] Because in the intervening sixteen years since *Roe v. Wade* women have come to rely on the rights guaranteed in that decision, compliance with laws severely restricting access to abortion, or even making it illegal, may well be even lower than compliance in the pre-*Roe* period.

While wealthier women may be able to seek legal abortions elsewhere, poorer women, a disproportionate share of whom are members of minority groups who do not have the option to travel or the luxury of private

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[36] The experience in European countries, for example, demonstrates that the severity or leniency of a country's abortion law is unrelated to the frequency of abortion. *See* Wessel and Segal, Book Review, 8 Prob. L.J. 349, 353-354 (1988); Glendon, *Abortion and Divorce in Western Law; American Failures, European Challenges*, at 14-15, 59-60 (1987). For example, irrespective of the legality or illegality of abortion, in the countries surveyed, women could obtain first trimester abortions. Wessel and Segal, *supra*, at 353. In addition, the strictness of a country's law has little to do with rates of abortion. Thus the Netherlands, with a lenient statute, experiences a low rate of abortion, and Rumania with a very strict law, has a rate higher than the U.S. *Id.*, at 353-54; Glendon, *Abortion and Divorce*, *supra*, at 59-60.

[37] *See, e.g.*, Task Force Report, *supra* note 16, at 105-07; Ziff, *supra* note 17, at 6-8, 11; Schwartz, *Morals Offenses and the Model Penal Code*, 63 Colum. L. Rev. 682 (1963).

physicians, will risk death, mutilation, infections, sterility, and other serious complications at the hands of illegal abortionists or at their own hands. Task Force Report, *supra* at 105-07; Ziff, *supra* at 6-9. The widespread demand for abortion will be met both by "some highly respectable physicians [who] regard the law as an injustice and want to protect their patients against incompetent abortionists," and by clandestine operators "ready to run the risk to earn the high fees." Task Force Report, *supra* at 105; Ziff at 9.[38] Bans on abortion "tend to foster organized forms of criminality which, with alarming business efficiency and the use of systematic means of coercion, violence, and governmental corruption, continue to supply the persistent demand . . . with the loss of substantial number of lives as a consequence." Task Force Report, *supra* at 107.

Enforcement of restrictive abortion laws will be difficult for several reasons. Detection, surveillance, apprehension, and proof will be problematic because of the frequent absence of a complaining victim, the private, consensual nature of the crime, the federal and state constitutional privileges against self-incrimination,[39] and

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[38] The prevalence of abortion "mills" and "rings" once led police to consider criminal abortion the third largest illegal endeavor in the country, after only gambling and narcotics. *See* Schur, *Crimes Without Victims* 25 (1965), cited in Ziff, *supra* note 17, at 5 n.30.

[39] Task Force Report, *supra* note 17, at 106; Ziff, *supra* note 18, at 8; Constitutional Aspects of the Right to Limit Childbearing, A Report of the United States Comm'r on Civil Rights, 94-95 (April 1975).

new abortifacients such as the morning after pill and R.U. 486.[40] Moreover, the reallocation of the resources necessary to attempt to enforce such laws will divert the resources of the police from protecting the public from other crimes, such as drug use and its attendant violence, and cause a "loss of morale and self-esteem among police who are obligated to engage in tasks which must seem to them demeaning or degrading or of little relevance to the mission of law enforcers." Task Force Report, *supra* at 107.

Given divided community opinion prevailing in many States, there may be a lack of uniform enforcement. Selective prosecution and inconsistent jury verdicts will undermine *amici's* efforts to foster uniform, consistent law enforcement in their States. In addition, selective prosecution and inconsistent verdicts for violation of unpopular laws will foster "cynicism and indifference to the criminal law and its agencies of enforcement," Task Force Report at 106, and it will tend "to contribute to antagonism and resentment toward those who enforce the law." *Id.* at 105; *see also* Ziff, *supra* at 8-10.

In sum, the heavy social costs of permitting States to severely restrict the availability of abortion would undermine the *amici's* interests in protecting the public health, safety and welfare, and in preserving the integrity of state criminal justice systems.

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[40] *See generally* N.Y. Times, Sept. 29, 1988, § B, at 11, cols. 4-5 (describing drugs that induce abortion).

CONCLUSION

For these reasons, *amici* Attorneys General respectfully request the Court to reaffirm and apply *Roe v. Wade* in this case.

Dated: October 13, 1989

Respectfully submitted,

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AMICUS CURIAE

BRIEF

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No. 88-790

In The
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BERNARD J. TURNOCK, M.D., M.P.H.,
Director of the Illinois Department
of Public Health, *et al.*,

Appellants,

v.

RICHARD M. RAGSDALE, M.D., *et al.*,

Appellees.

On Appeal From the United States
Court of Appeals For the Seventh Circuit

BRIEF OF CERTAIN ILLINOIS SENATORS AND REPRESENTATIVES AS AMICI CURIAE IN SUPPORT OF APPELLEES

(Amici listed inside front cover)

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

STATEMENT OF INTEREST 1

SUMMARY OF THE ARGUMENT 2

ARGUMENT 2

A. INTRODUCTION 2

B. THE CHALLENGED STATUTES AND REGULATIONS SEEK TO DEFEAT THE EXERCISE OF A WOMAN'S RIGHT TO REPRODUCTIVE CHOICE 4

1. The Express Intent Of The Illinois Legislature Was Hostile To The Exercise Of Reproductive Choice 4

2. The Express Provisions Of The Statutes Unduly Discriminate Against Abortion 6

3. The Impact Of The Regulatory Scheme Unconstitutionally Encumbers Reproductive Choice 9

C. LEGISLATIVE AND REGULATORY RESTRICTIONS ON A WOMAN'S RIGHT TO CHOOSE MUST BE NARROWLY TAILORED AND SUPPORTED BY A COMPELLING STATE INTEREST 10

D. THE REGULATORY SCHEME AT ISSUE COMPROMISES PERSONAL RIGHTS AND SERVES NO MEDICAL PURPOSE 12

E. OTHER AMICI MISSTATE THE INTENT OF THE LEGISLATURE AND THE EFFECT OF THE STATUTES AND REGULATIONS 15

CONCLUSION 16

TABLE OF AUTHORITIES

CASES *Page*

Akron v. Akron Center for Reproductive Health, 462 U.S. 416 (1983) 11

Bibb v. Navajo Freight Lines, Inc., 359 U.S. 520 (1959)..... 16

Brown v. Board of Education, 347 U.S. 483 (1954)..... 4

Carey v. Population Services, International, 431 U.S. 678 (1977) 11

Kassel v. Consolidated Freightways Corp., 450 U.S. 662 (1981)..... 16

Ragsdale v. Turnock, 625 F.Supp. 1212 (N.D. Ill. 1985) .... *passim*

Ragsdale v. Turnock, 841 F.2d 1358 (7th Cir. 1988), juris. post., 109 S.Ct. 3239 (1989)..... 4, 8, 10

Roe v. Wade, 410 U.S. 113 (1973) ..... *passim*

Swann v. Charlotte-Mecklenberg Board of Education, 402 U.S. 1 (1971)..... 4

Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747 (1988) 11, 15

Webster v. Reproductive Health Services, Inc., 109 S.Ct. 3040 (1989) 9, 11, 12, 14, 15

West Virgina State Board of Education v. Barnette, 319 U.S. 624 (1962)..... 14

Wisconsin v. Yoder, 406 U.S. 205 (1972)..... 15

STATUTES

Ambulatory Surgical Treatment Center Act (ASTCA) Ill. Rev. Stat., ch. 111½ §157-8.1 *et seq.* (1987) ..... *passim*

Health Facilities Planning Act, Ill. Rev. Stat., ch. 111½ §1151 *et seq.* (1987) 3, 8

Page

Medical Practice Act, Ill. Rev. Stat., ch. 111 §4433(1) (1987) 3, 9

LEGISLATIVE HISTORY

78th Ill. Gen. Assem., Senate Proceedings (various dates)..... 5, 6, 12

78th Ill. Gen. Assem., House Proceedings (various dates)..... 4, 5, 12

MISCELLANEOUS

Fed. R. Civ. P. 52(a) 10

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STATEMENT OF INTEREST

Amici Curiae constitute a bipartisan group of Illinois legislators who share the opinion of this Court set forth in *Roe v. Wade*, 410 U.S. 113 (1973), that the Constitution protects, as a fundamental right, a woman's right to make various reproductive choices, including the decision to terminate her pregnancy. Although these *Amici Curiae* have differing personal views on the question of abortion, they are united in their

commitment to the principle that the government's pre-emption of a woman's choice, if sustainable at all, must be very carefully circumscribed.

As Illinois legislators, these *Amici Curiae* have an interest in enacting legislation that is constitutionally sound. They believe the Illinois laws at issue here unduly burden a woman's fundamental right of choice, are motivated by constitutionally improper purposes and cannot pass the strict scrutiny required by this Court. It is the position of these *Amici Curiae* that the legislative enactments before this Court must be struck down.

SUMMARY OF THE ARGUMENT

In enacting the Ambulatory Surgical Treatment Center Act in 1973, the Illinois General Assembly was overwhelmingly concerned with the issue of abortion and restricting a woman's access to this procedure following the Court's decision in *Roe v. Wade*, 410 U.S. 113 (1973). Frustrated by their inability to ban abortion outright, the sponsors of the legislation sought to use stringent regulation and powerful penalties to ensure that abortion would not be widely available. The act, and subsequent related legislation and regulations, unconstitutionally encumber the exercise of the fundamental right of choice repeatedly recognized by this Court.

ARGUMENT

A. INTRODUCTION

Three interrelated statutes are the focus of this appeal. The first, and most central, is the Ambulatory Surgical Treatment Center Act ("ASTCA"), Ill. Rev. Stat., ch. 111½ §157-8.1 *et seq.* (1987), and its regulations. ASTCA purports to regulate:

> any institution, place or building devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures or *any facility in which a medical or surgical procedure is utilized to terminate a pregnancy irrespective of whether the facility is devoted primarily to this purpose.*

Ill. Rev. Stat., ch. 111½ §157-8.3 (emphasis added).

What ASTCA does is to sweep any facility or office which performs even a single abortion into the vast regulatory apparatus pursuant to which full ambulatory surgical centers are subject. The apparatus includes not only statutory provisions but an array of abortion-specific regulations. The regulations do not apply to any ambulatory or outpatient procedures other than abortions even though many such procedures are of equivalent or greater risk than an abortion — particularly an abortion in the first trimester.

The second related statute before the Court is Section 16-1 of the Illinois Medical Practice Act., Ill. Rev. Stat., ch. 111 §4433(1) (1987). It authorizes the Department of Registration and Education to revoke or suspend the license of a physician who performs even one abortion outside of a hospital or a licensed Ambulatory Surgical Treatment Center ("ASTC").

The third statute is the Health Facilities Planning Act, Ill. Rev. Stat., ch. 111½ §1151 *et seq.* (1987), which requires ASTCs, like hospitals, to obtain a certificate of need ("CON") prior to constructing, renovating or relocating their facilities. This act prohibits certain physicians and facilities from providing abortions unless they submit to public hearings and, as a consequence, subjects them to a potential veto and intimidation by hostile opponents.

The issue on this appeal is whether or not these provisions unconstitutionally burden a woman's choice to terminate her pregnancy very early in that pregnancy. This case concerns first and early second trimester abortions — traditionally the safest and most free from complications. It is the position of the *Amici Curiae* that the burden imposed by these statutes on the choice to terminate a pregnancy in its earliest stages cannot pass constitutional muster.

B. THE CHALLENGED STATUTES AND REGULATIONS SEEK TO DEFEAT THE EXERCISE OF A WOMAN'S RIGHT TO REPRODUCTIVE CHOICE

1. The Express Intent Of The Illinois Legislature Was Hostile To The Exercise Of Reproductive Choice

The context for the passage of ASTCA by the Illinois legislature provides an important backdrop to a discussion of its constitutionality. That context, in many ways, distinguishes ASTCA from other restrictions on abortion sustained by this and other courts. The debates reveal an aggressive and unambiguous intent to regulate abortions out of existence.

Immediately following *Roe v. Wade*, 410 U.S. 113 (1973), the Illinois legislature developed a variety of strategies to subvert the effect of this Court's ruling. In many respects, the strategy and tactics of certain legislators echoed attempts to evade the impact of *Brown v. Board of Education*, 347 U.S. 483 (1954), some twenty years earlier. As *Brown v. Board of Education* spawned an array of legislative enactments attempting to forestall orderly school integration, *see Swann v. Charlotte-Mecklenburg Board of Education*, 402 U.S. 1, 13-14 (1971), so *Roe v. Wade* spawned the strategy at issue here of subjecting a simple, safe, office procedure to the panoply of regulations and licensure applicable to full-scale surgical centers — in effect, requiring a physician who performs even a single abortion at the earliest stage of a pregnancy to build (in the Seventh Circuit's phrase) "the functional equivalent of small hospitals." *Ragsdale v. Turnock*, 841 F.2d 1358, 1374 (7th Cir. 1988).

Representative Henry Hyde, a major supporter of ASTCA and leading spokesperson for the anti-choice forces in the legislature in 1973, spoke unambiguously about the purpose of ASTCA:

> I know that the Supreme Court has saddled this Country with a decision that . . . ah . . . renders a human life subordinate to that of . . . a . . . ah . . . of animal life really . . . ah . . . and we are going to have

> abortions in this State as a result of that . . . ah . . . decision. *And it seems to me that . . . ah . . . we must make the best of a very sorry situation by at least regulating that procedure so that the Abortion Mills will not proliferate.*

House Proceedings, July 1, 1973, Appellee's Appendix ("App.") at A.41-42 (emphasis added).

As Representative Hyde's remarks make clear, the intent of the legislature was to restrict a woman's right to choose *not* because of "content neutral" health or safety considerations (as argued by the State of Illinois on this appeal), but because certain legislators disagreed with the principle that women had the right to choose to terminate a pregnancy.

Some legislators were reluctant to vote for ASTCA, preferring instead to leave Illinois law banning abortions untouched. These legislators assumed they could simply wait for politics to change the Court. Representative Walsh:

> Mr. Speaker . . . I would like to point out that what we are doing here is reacting to a Supreme Court decision . . . Now it hasn't been too long since we've seen the Supreme Court reverse itself in the area of reapportionment, in the area of pornography. They do it regularly. I feel like they'll see the light in this very important area that we're discussing today. I refuse to support these bills and intend to be recorded as voting present.

House Proceedings, July 1, 1973, App. at A.44-45.

The alternative to the "stand pat" approach was to adopt a series of regulations and prohibitions which, while not outlawing the procedure as a matter of principle, would make it impossible, *as a practical matter*, for most women to obtain an abortion. This approach prevailed. Ultimately, Senator Wooten, the Senate sponsor of the bill, argued openly that ASTCA would in effect perpetuate Illinois' prior ban on abortion, notwithstanding this Court's decision in *Roe v. Wade*:

Sen. Ozinga:

> Mr. President, this is a good example of . . . you give them an inch, they want a mile. Now, right off the bat, you have just voted on allowing abortions in Illinois. Ok, so we're opening the door wide open already by having an ambulatory services come right to the door if you need it. This is ridiculous.

Sen Wooten, in responding to Sen Ozinga:

> I'm afraid you've misstated the situation Senator. We did not do anything in any of these series of bills to permit abortion. That has been done by the Supreme Court. All we have done is change *language* to bring our Illinois statutes in line with the Supreme Court. We really don't change the law . . . the *practical effect* of the law [banning abortions] one way or the other.

Senate Proceedings, June 1, 1973, App. at A.20 (emphasis added).

These expressions of intent, although no substitute for a critical analysis of the statute itself, demonstrate two important points. First, contrary to what the Appellants argue here, health and safety had little to do with the inclusion of abortions in the regulatory scheme established by ASTCA. Rather, it was an open attempt to constrain the exercise of a woman's right to choose to terminate her pregnancy. Second, the comments by the legislators evidence an animus which — unlike sustainable regulatory intervention in the latter stages of a pregnancy — sought to make obtaining the procedure as thoroughly difficult as possible from the first day of pregnancy forward.

2. The Express Provisions Of The Statutes Unduly Discriminate Against Abortion

The anti-choice animus reflected in the legislative debate over ASTCA and briefly described above resulted in the legislative scheme at issue before this Court. The language of all three enactments evidences what Representative Hyde and others contemplated: a comprehensive regulatory scheme which restricts access to abortions irrespective of any health concerns or

constitutional limitations. The definition of facilities subject to ASCTA includes centers devoted to extensive ambulatory surgical care and *any* facility utilized to terminate *any* pregnancy including *any* doctor's office. Of all of the ambulatory surgical procedures currently available, only abortions have their own set of comprehensive ASCTA regulations. These factors alone illustrate the degree to which the performance of abortions was singled out as a regulatory target.

Substantively, ASTCA requires that facilities performing abortions at any stage of a pregnancy — including the first few weeks — subject themselves to a labyrinth of irrelevant regulations with which they must comply to obtain a license. These regulations intrude on almost every aspect of the provision of abortion services, from personnel policies, to facility maintenance, to building design, construction standards and physical requirements, to mechanical and plumbing requirements. For example, the provision which applies to building design, construction standards and physical requirements contains 11 separate regulations with 122 individual subparts. It demands that *all* physicians performing abortions, even in their offices "meet . . . [its] physical plant and surgical requirements" before licensure will be granted. Regulation 205.1310. These include:

> (1) a minimum size of 250 sq. ft. for at least one procedure room (any additional ones must be no smaller than 120 sq. ft.) and a minimum of 80 sq. ft. for examination rooms;
>
> (2) that an ASTC be "identifiably separate from other medical facilities and functions";
>
> (3) that a "control station" be located to allow visual surveillance of traffic entering the operating suites;
>
> (4) that facilities including a lounge, lockers, separate toilets, and a space for changing clothes be provided for male and female personnel;
>
> (5) a separate janitorial closet for the surgical suite;
>
> (6) a "diagnostic facility" if pre-admission evaluation tests are to be performed;

> (7) minimum corridor (5' or 8' depending on whether stretchers are to be used) and door (3' or 3'8") widths; and
>
> (8) An elaborate air-conditioning, heating, and ventilation system to provide for specific filter efficiency and air-flow relationships between rooms.

Regulation §§205.1310-90, 1540 and Table A.

The regulations also require: (a) the physcian who is to perform the abortion perform his or her own test on the patient regardless of whether testing had been previously done; (b) that counseling be provided, including mandatory presentation of alternatives, the risk of the procedure, and an explanation of the procedure, and (c) that the counselor have no financial interest in the procedure. As the Seventh Circuit noted these regulations intrude "upon the discretion of the pregnant woman's physician and thereby impose[ ] the 'undesired and uncomfortable straitjacket' which the Court has rejected [in *Thornburgh*]." *Ragsdale v. Turnock*, 841 F.2d at 1372-73.

As previously noted, the Health Facilities Planning Act, Ill. Rev. Stat., ch. 111½ §1151 *et seq.* (1987), requires that any clinic or physician performing these procedures obtain a CON permit prior to operation. Such CONs are obtained from the Department of Public Health after a public hearing and a 120-day review period. The record below illustrates precisely what happens when the state holds public hearings to establish, relocate or renovate a facility which performs abortions — when Dr. Ragsdale attempted to relocate his office and abide by these requirements, the public hearing degenerated into a threatening shouting match over abortion. Approximately 1200 people attended the hearing on March 14, 1985. Dr. Ragsdale and his family had to be escorted to safety. Dr. Ragsdale's potential landlord withdrew the site within 48 hours after the hearing. *Ragsdale v. Turnock*, 625 F.Supp. 1212, 1226 (N.D.Ill 1985).

Amici Curiae, as legislators, have never shied away from a good shouting match. But one cannot condition the exercise of fundamental rights on the outcome of such volatile political encounters. To do so is to grant the public veto power over the assertion of constitutional rights. This is a most dangerous course.

Finally, these statutes grant to the state the power to impose severe sanctions on persons who assist others in the exercise of their constitutional rights. In *Webster v. Reproductive Health Services, Inc.*, 109 S.Ct. 3040 (1989), the Court noted that in such settings, constitutional inquiry is most rigorous:

> Constitutional concerns are greatest . . . when the State attempts to impose its will by the force of law.

Id. at 3052.

A physician who performs a single first trimester abortion contrary to the scheme imposed by the enactments may have his or her license revoked. Ill. Rev. Stat., ch. 111 §4433(1) (1987). Violating the ASTCA can result in forced closure of an abortion facility, Ill. Rev. Stat., ch. 111½ §157.8.9(a), and fines of up to $10,000 per day. *Id.* at §157-8.1(2).

3. The Impact Of The Regulatory Scheme Unconstitutionally Encumbers Reproductive Choice

The impact of the statutory scheme at issue here is precisely what the legislative sponsors of ASTCA had hoped for in 1973. These provisions actively discourage women from exercising their consitutional right to terminate pregnancies.

In granting the preliminary injunction, the District Court found:

> In the present case, plaintiffs have overwhelmingly demonstrated the burden that the challenged statutory and regulatory scheme places on a woman's right to choose to terminate her pregnancy during the first and early second trimester . . . . Here, plaintiffs have demonstrated that the challenged scheme substantially interferes with the pregnancy termination decision during the first and early second trimester.

Ragsdale v. Turnock, 625 F.Supp. at 1230.

After reviewing the evidence heard by the District Court, the Seventh Circuit concluded that:

> [T]he physical plant equipment and staffing requirements, in particular, seem totally unjustified from a medical standpoint. The testimony regarding many of the physical plant requirements makes clear that they have "no medical justification whatsoever" when applied to first and early second trimester abortions of the type involved in this case . . . .
>
> . . . We agree [with the District Court] that the requirements that ASTC's performing first and early second trimester abortions be "the functional equivalents of small hospitals" are not sufficiently justified by important state health objectives to be sustained.

Ragsdale v. Turnock, 841 F.2d at 1373-74.

The findings of the District Court are amply supported by the evidence introduced at the hearing on the preliminary injunction. They are entitled to very substantial deference. *See* Fed. R. Civ. P. 52(a).

Remarkably, the defendants failed at the hearing in the District Court to produce any evidence of a compelling or even a rational basis for this byzantine array of restrictions and regulations. The District Court pointedly noted this failure and also noted that plaintiffs presented substantial unchallenged evidence demonstrating the opposite — namely, that ASTCA's requirements were, in fact, detrimental to the health and safety of women seeking to terminate their pregnancies. *Ragsdale v. Turnock*, 625 F.Supp. at 1230 n. 23.

C. LEGISLATIVE AND REGULATORY RESTRICTIONS ON A WOMAN'S RIGHT TO CHOOSE MUST BE NARROWLY TAILORED AND SUPPORTED BY A COMPELLING STATE INTEREST

In *Roe v. Wade*, this Court held that, "the right of privacy, . . . founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, . . . is broad enough to encompass a woman's decision whether or not to

terminate her pregnancy." 410 U.S. at 153. Since *Roe*, this Court "repeatedly and consistently has accepted and applied th[is] basic principle . . . . " *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 420 n.1 (1983) (citations omitted). As this Court stated in *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 772 (1986):

> Our cases long have recognized that the Constitution embodies a promise that a certain private sphere of individual liberty will be kept largely beyond the reach of government. That promise extends to women as well as men. Few decisions are more personal and intimate, more properly private, or more basic to individual dignity and autonomy, than a woman's decision — with the guidance of her physican and within the limits specified in *Roe* — whether to end her pregnancy. A woman's right to make that choice freely is fundamental. Any other result, in our view, would protect inadequately a central part of this sphere of liberty that our law guarantees equally to all. (Citations omitted).

State regulation which restricts the fundamental right of reproductive privacy is subject to strict judicial scrutiny. *Carey v. Population Services, International*, 431 U.S. 678, 686 (1977). The zone of permissible state regulation for abortion is narrow and circumscribed. Thus, as *Akron* noted, "restrictive state regulation of the right to choose abortion, as with other fundamental rights subject to searching judicial examination, must be supported by a compelling state interest." 462 U.S. at 427.

This Court's recent decision in *Webster v. Reproductive Health Services, Inc.*, 109 S.Ct. 3040 (1989), does not alter these standards. *Webster* left undisturbed "the right to an abortion derived from the Due Process Clause." Id. at 3058. The *Webster* Court upheld the Missouri statute because it could be read in harmony with *Roe*. The Missouri statute's prohibition on the use of public facilities or public employees to perform abortions, except where necessary to save the life of the mother, was valid because it "place[d] no governmental obstacle in the path of a woman who chooses to terminate her pregnancy." *Id.* at 3052. The statute's requirement of a test for viability for fetuses thought

to be at least twenty weeks gestational age was constitutional as a reasonable means by which the state safeguarded its compelling interest, as recognized in *Roe*, to ensure that abortions are not performed where the fetus is viable except where necessary to preserve the life and health of the mother. *Id.* at 3055.

D. THE REGULATORY SCHEME AT ISSUE COMPROMISES PERSONAL RIGHTS AND SERVES NO MEDICAL PURPOSE

Unlike the legislation upheld in *Webster*, the statutes and regulations at issue here place devastating obstacles in the path of a woman who chooses to terminate her pregnancy. This is no accident. The ASTCA was born out of legislative hostility to the rights recognized in *Roe* and was designed to regulate into oblivion what could not be banned outright. Thus, the Senate sponsor could assure his colleagues that "we really don't change the law . . . the practical effect of the law one way or the other," Senate Proceedings, June 1, 1983, App. at A.20, even where the prior law had banned abortions, and Representative Hyde supported the ASTCA because it was "at least regulating [the abortion] procedure so that the Abortion Mills will not proliferate." House Proceedings, July 1, 1973, App. at A.41-42.

The result of this legislation is to severely, if not fatally, encumber the right of choice. As the District Court found, following a full evidentiary hearing, these statutes and regulations irreparably injure constitutional rights:

> [T]he challenged statutes and regulations do place a very real and a very heavy burden on the right of a woman to decide to terminate her pregnancy. The effect of the statutory and regulatory scheme is to increase the cost of abortions and decrease their availability. As a result of the scheme, Margaret Moe does not provide abortion services at her two Illinois clinics even though the physicians at the clinics are ready, willing, and able to perform abortions, and even though approximately sixty patients a week at the clinics request an abortion. Also, as a result of the scheme, the NIWC, the only outpatient abortion facility

> in northwest Illinois, will close at the end of the year without a relocation site.
>
> The effect on women desiring to terminate their pregnancies, as clarified by the hearing testimony of Margaret Moe, is enormous. First, many women are not able to obtain an abortion in their own community, and they may find it difficult to secure a means of transportation to the nearest abortion facility, which may, in fact, be quite a distance from their community. Having to make travel plans, arrange a day off and negotiate a loan, and then actually having to travel some distance to an abortion facility may delay the abortion and thereby increase the health risk or prevent the abortion altogether. Also, travelling a distance subjects a woman to greater expense, as the woman must pay for the cost of transportation and may need to hire a babysitter or miss a day of work and lose that day's pay. In addition, other factors affecting a woman's decision to terminate her pregnancy, such as her confidence in the competency of the physician performing the abortion and her ability to return for follow-up care, would be adversely affected if the woman were required to travel a great distance to obtain an abortion.

Ragsdale v. Turnock, 625 F. Supp. at 1227 (footnotes omitted).

Unlike those in *Webster*, the statutes and regulations here serve no compelling interest. Again, the District Court determined after a full evidentiary hearing that:

> Defendants . . . have failed to produce any evidence at all of a compelling or even rational basis for the challenged statutes and regulations. The defendants presented no evidence in their pleadings or at the hearing that the statutes or regulations are medically necessary. Dr. Barton, the defendant's expert in obstetrics and gynecology, testified at the hearing that he was of the opinion that there was a medical necessity for some regulation by the state of outpatient abortion facilities, but Dr. Barton did not testify as to the medical

> necessity of any of the statutes or regulations here challenged. Also, Dr. Barton agreed that there is no medical reason to single out abortion from other medically analogous procedures for different regulation.

Id. at 1230 (footnote omitted).

On the contrary, the evidence in the record shows the regulatory scheme before the Court could be detrimental to maternal health:

> Plaintiffs, . . . presented testimony by Dr. Ragsdale and Dr. Hern that the regulations are not only medically unnecessary, but some of the regulations, particularly those requiring ASTCs to be hospital-like facilities, may be medically detrimental, for women often find it psychologically reassuring when they are able to effectuate their decision to abort in a comfortable, more personalized atmosphere.

Id. at 1230 n.23.

The challenged statutes and regulations highlight in bold relief the warning expressed in *Webster*, that "constitutional concerns are greatest . . . when the State attempts to impose its will by the force of law." 109 S. Ct. at 3052. It is a stark reminder of this Court's duty to vigilantly protect constitutional rights from legislative erosion. As a fundamental right, a woman's decision whether to terminate her pregnancy should not be subject to legislative whim:

> The very purpose of a Bill of Rights was to withdraw certain subjects from the vicissitudes of political controversy, to place them beyond the reach of majorities and officials and to establish them as legal principles to be applied by the courts.

West Virginia State Board of Education v. Barnette, 319 U.S. 624, 638 (1942).

Webster recognizes that to preserve effectively cherished constitutional freedoms courts must both properly define the parameters in which legislators may act constitutionally and

strictly patrol those borders to guarantee that the Constitution is upheld:

> The goal of constitutional adjudication is to hold true the balance between that which the Constitution puts beyond the reach of the democratic process and that which it does not.

109 S. Ct. at 3058

E. OTHER AMICI MISSTATE THE INTENT OF THE LEGISLATURE AND THE EFFECT OF THE STATUTES AND REGULATIONS

Amici in support of Appellants attempt to mislead this Court in suggesting that the ASTCA and its abortion-specific regulations were enacted in response to a 1978 Chicago Sun-Times/Better Government Association expose detailing instances of abuse at certain Chicago-area abortion clinics. *See* Brief of Certain Illinois Senators and Representatives as *Amici Curiae* in Support of Appellants ("Other Amici"). While certain additional encumbrances were placed upon the abortion procedure following these newspaper articles, the basic framework which singled out abortion from among other, often riskier, outpatient surgical procedures for strict regulation and licensure was passed in 1973 — five years earlier — in a *direct* attempt to subvert the rights recognized in *Roe*.

Moreover, the existence of abuses at abortion clinics does not justify an unconstitutional intrusion into fundamental rights. As this Court stated in *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. at 759, "the States are not free, under the guise of protecting maternal health or potential life, to intimidate women into continuing pregnancies." Even if the legislators' motives were as pure as depicted by Other Amici, they cannot redeem a statutory scheme that unconstitutionally impairs a woman's ability to exercise her right to terminate her pregnancy. "[A] regulation neutral on its face may, in its application, nonetheless offend the constitutional requirement for governmental neutrality if it unduly burdens a fundamental right." *Wisconsin v. Yoder*, 406 U.S. 205, 220 (1972)

(neutral compulsory education law cannot be applied to members of Amish religion who claim that their "free exercise" First Amendment right was burdened). *Cf. Bibb v. Navajo Freight Lines, Inc.* 359 U.S. 520 (1959) (purported safety justification cannot support truck mud-flap requirement which imposes untenable burden on interstate commerce); *Kassel v. Consolidated Freightways Corp.*, 450 U.S. 662 (1981).

Finally, Other Amici attempt to demonstrate that the passage of ASTCA in 1973 was unrelated to abortion and was motivated solely by a concern for health and safety in all ambulatory settings. This is nonsense. Despite Other Amici's selective citation of passages from the 1973 debate in which procedures other than abortion were discussed, the plain statements of the legislators cited above and the statutes and regulations themselves show a specific intent to keep the practical effect of Illinois law the same as it was pre-*Roe*.

CONCLUSION

For the reasons stated, the decision of the United States Court of Appeals for the Seventh Circuit should be affirmed.

Respectfully submitted,

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BRIEF

(30)

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, *et al.*,

Appellants,

—v.—

RICHARD M. RAGSDALE, M.D., *et al.*,

Appellees.

ON APPEAL FROM THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

STATE OF OHIO,

Appellant,

—v.—

AKRON CENTER FOR REPRODUCTIVE HEALTH, *et al.*,

Appellees.

ON APPEAL FROM THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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145 pp

TABLE OF CONTENTS

PAGE

TABLE OF AUTHORITIES iii

INTEREST OF AMICI 2

SUMMARY OF ARGUMENT 2

ARGUMENT 3

I. *ROE v. WADE* CORRECTLY HELD REPRODUCTIVE CHOICE TO BE A FUNDAMENTAL CONSTITUTIONAL RIGHT, ROOTED IN TRADITIONAL CONCEPTIONS OF LIBERTY AND PRIVACY 3

A. Reproductive Choice Is Essential to a Woman's Control of Her Destiny and Family Life 4

B. Keeping Reproductive Choice in Private Hands Is Essential to a Free Society 10

II. EVEN IF CONSTITUTIONAL PRIVACY PRINCIPLES DID NOT SO PLAINLY PROTECT THE RIGHT TO ABORTION, EQUAL PROTECTION PRINCIPLES WOULD DO SO 13

A. Sex Classifications that Interfere with Bodily Integrity and Procreation Are Impermissible in the Absence of Compelling Justification. 13

B. Restrictive Abortion Laws Classify on the Basis of Sex 15

C. The Political Process Is Inadequate to Protect Access to Abortion for All Women ... 18

PAGE

III. ONLY THE MOST COMPELLING INTERESTS MAY JUSTIFY STATE INTERFERENCE WITH THE ABORTION RIGHT, AND ONLY WHERE SUCH REGULATION IS NARROWLY TAILORED TO THOSE INTERESTS 20

A. Strict Scrutiny Properly Invalidates any Abortion Regulation Not Proven Necessary to Protect the Woman's Health or to Protect Potential Life 22

B. Any Significant Regulatory Interference with the Abortion Right Triggers Strict Scrutiny 25

CONCLUSION 29

TABLE OF AUTHORITIES

Cases: PAGE

Akron v. Akron Center for Reproductive Health, 462 U.S. 416 (1983) 24, 26, 27, 28

Bellotti v. Baird, 443 U.S. 622 (1979) 27

Bolling v. Sharpe, 347 U.S. 497 (1954) 4

Bradwell v. Illinois, 16 Wall. 130 (1873) 16, 17

Califano v. Goldfarb, 430 U.S. 199 (1977) 14, 16, 18

Carey v. Population Services International, 431 U.S. 678 (1977) 7

City of Richmond v. J. A. Croson Co., 109 S. Ct. 706 (1989) 21, 22, 24

Cleveland Board of Education v. LaFleur, 414 U.S. 632 (1974) 16

Doe v. Bolton, 410 U.S. 179 (1973) 4

Eisenstadt v. Baird, 405 U.S. 438 (1972) 5, 8

Everson v. Board of Education, 330 U.S. 1 (1947) 12

Frontiero v. Richardson, 411 U.S. 677 (1973) 13, 14, 17

Geduldig v. Aiello, 417 U.S. 484 (1974) 15, 16

General Electric Co. v. Gilbert, 429 U.S. 125 (1976) 16

Griswold v. Connecticut, 381 U.S. 479 (1965) ..... *passim*

Harper v. Virginia Board of Elections, 383 U.S. 663 (1966) 4

PAGE

Harris v. McRae, 448 U.S. 297 (1980) 25

Hodgson v. Minnesota, 853 F.2d 1452 (8th Cir. 1988) (en banc), *cert. granted*, 109 S. Ct. 3240 (1989) (Nos. 88-1125, 88-1309) 28

Kirchberg v. Feenstra, 450 U.S. 455 (1981) 13

Kovacs v. Cooper, 336 U.S. 77 (1949) 10

Kramer v. Union Free School District, 395 U.S. 621 (1969) 20

Loving v. Virginia, 388 U.S. 1 (1967) 5

Lynch v. Donnelly, 465 U.S. 668 (1984) 27

Maher v. Roe, 432 U.S. 464 (1977) 25

Meyer v. Nebraska, 262 U.S. 390 (1923) 2, 4, 10

Michael M. v. Sonoma County Superior Court, 450 U.S. 464 (1981) 5, 15

Mississippi University for Women v. Hogan, 458 U.S. 718 (1982) 13, 14

Moore v. City of East Cleveland, 431 U.S. 494 (1977) 5, 8, 11

NAACP v. Alabama, 357 U.S. 449 (1958) 4

Nashville Gas Co. v. Satty, 434 U.S. 136 (1977) 16

New State Ice Co. v. Liebman, 285 U.S. 262 (1932) 12

Perry Education Association v. Perry Local Educators' Association, 460 U.S. 37 (1983) 23

Personnel Administrator v. Feeney, 442 U.S. 256 (1979) 15

PAGE

Pierce v. Society of Sisters, 268 U.S. 510 (1925) 2, 4, 10

Planned Parenthood v. Danforth, 428 U.S. 52 (1976) 27, 28

Poe v. Ullman, 367 U.S. 497 (1961) 12

Railway Express Agency v. New York, 336 U.S. 106 (1949) 18, 20

Reed v. Reed, 404 U.S. 71 (1971) 14

Reynolds v. Sims, 377 U.S. 533 (1964) 4

Richmond Newspapers, Inc. v. Virginia, 448 U.S. 555 (1980) 4

Rochin v. California, 342 U.S. 165 (1952) 6

Roe v. Wade, 410 U.S. 113 (1973) .....*passim*

Schlesinger v. Ballard, 419 U.S. 498 (1975) 14

Shapiro v. Thompson, 394 U.S. 618 (1969) 4, 20

Skinner v. Oklahoma, 316 U.S. 535 (1942) 12, 14, 15, 18

Stanton v. Stanton, 421 U.S. 7 (1975) 14, 17-18

Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747 (1986) .....*passim*

United States v. Ballard, 322 U.S. 78 (1944) 12

Webster v. Reproductive Health Service, 109 S. Ct. 3040 (1989) 4, 6, 12, 18

Weinberger v. Wiesenfeld, 420 U.S. 636 (1975) 14, 16, 18

West Virginia State Board of Education v. Barnette, 319 U.S. 624 (1943) 11, 12, 25

PAGE

Whalen v. Roe, 429 U.S. 589 (1977) 7

Winston v. Lee, 470 U.S. 753 (1985) 6

Wygant v. Jackson Board of Education, 476 U.S. 267 (1976)..... 21

Zablocki v. Redhail, 434 U.S. 374 (1978) 14-15, 15

Statutes:

Pregnancy Discrimination Act of 1978, Pub. L. No. 95-555, 92 Stat. 2076 (amending 42 U.S.C. § 2000e) 16

Other Authorities:

M. Atwood, *The Handmaid's Tale* (1985) 10

Brief *Amicus Curiae* for American Jewish Congress, *et al.*, *Webster v. Reproductive Health Service*, 109 S. Ct. 3040 (1989)..... 12

Brief for United States as *Amicus Curiae* Supporting Appellants, *Webster v. Reproductive Health Service*, 109 S. Ct. 3040 (1989)..... 8

Brief of 281 American Historians as *Amici Curiae* Supporting Appellees, *Webster v. Reproductive Health Service*, 109 S. Ct. 3040 (1989) 17

Cates & Rochat, *Illegal Abortions in the United States: 1972-1974*, 8 Fam. Plan. Persp. 86 (1976) 20

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PAGE

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

Nos. 88-790 and 88-805

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, *et al.*,
Appellants,

—v.—

RICHARD M. RAGSDALE, M.D., *et al.*,
Appellees.

ON APPEAL FROM THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

STATE OF OHIO,
Appellant,

—v.—

AKRON CENTER FOR REPRODUCTIVE HEALTH, *et al.*,
Appellees.

ON APPEAL FROM THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

BRIEF OF *AMICI CURIAE* 274 ORGANIZATIONS IN SUPPORT OF *ROE v. WADE* ON BEHALF OF APPELLEES

INTEREST OF *AMICI*

This brief is filed on behalf of 274 organizations, representing literally millions of individuals, which have joined together in an unprecedented alliance to urge this Court to reaffirm *Roe v. Wade*, 410 U.S. 113 (1973). *Amici* are Americans of both genders, all races, and most religions. They are Nobel Prize winners, government workers, teachers, religious activists, doctors, and lawyers. In short, they reflect the diversity of our society and the breadth of its support for constitutionally protected reproductive rights. From a multiplicity of perspectives, they have united in signing this brief as an expression of their belief that the promise of liberty and equality cannot be fulfilled without privacy and reproductive choice.

Amici have the consent of the parties to file this brief. Letters of consent have been filed separately in this Court. A complete list of a*mici* and their statements of interest are set forth at Appendix A.

SUMMARY OF ARGUMENT

For most of the twentieth century, this Court has held that government may not interfere with our family lives, or our most intimate decisions, unless it has the strongest possible reason. From *Meyer v. Nebraska*, 262 U.S. 390 (1923), and *Pierce v. Society of Sisters*, 268 U.S. 510 (1925), which held fundamental the right to educate one's children, to *Griswold v. Connecticut*, 381 U.S. 479 (1965), and succeeding cases, which held fundamental the right to use contraceptives, this Court has held the right of privacy to be a basic value implicit in the concept of ordered liberty. *Roe v. Wade*, 410 U.S. 113 (1973), correctly applied this principle to a woman's right to choose abortion. For few decisions are more appropriate to the private sphere of individual liberty than the uniquely personal, intimate, and self-defining decision whether or not to continue a pregnancy. This is so because of the central importance of this decision to the woman, and the value of keeping the state out of the business of

reproductive control. Thus *Roe* was correctly decided and should be reaffirmed.

If the basic principle of constitutional privacy affirmed in this Court's contraception and abortion cases should ever be doubted, an alternative basis for reaffirming *Roe* may readily be found in the Equal Protection Clause. Because restrictive abortion laws not only discriminate uniquely against women, but do so in a way that intrudes on women's most basic interests in health, bodily integrity, procreation, and family formation, they must be strictly scrutinized.

Because the right to choose abortion is fundamental on either of these theories, regulation of that right may be justified only by the state's demonstration of a compelling interest to which the regulation is narrowly drawn. In *Roe*, this Court set forth a careful framework for evaluating such interests that has been both sound and workable since. Under any fair application of that framework, this Court must strike down regulations, like those enacted by Ohio and Illinois here, that significantly burden a woman's right to choose abortion while serving closely no compelling interest.

ARGUMENT

I. *ROE v. WADE* CORRECTLY HELD REPRODUCTIVE CHOICE TO BE A FUNDAMENTAL CONSTITUTIONAL RIGHT, ROOTED IN TRADITIONAL CONCEPTIONS OF LIBERTY AND PRIVACY.

Roe v. Wade held the "right of privacy . . . founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action . . . broad enough to encompass a woman's decision whether or not to terminate her pregnancy." *Roe v. Wade*, 410 U.S. 113, 153 (1973). In so doing, *Roe* did not declare an absolute right to abortion, but simply announced that any government restricting access to abortion would be put to an exacting test: regulation of the abortion decision "may be justified only by a 'compelling state interest' " to which it is "narrowly drawn." *Id.* at 155.

This Court has never renounced this holding, and should not do so now.[1] *Roe* was correct because the decision whether to continue a pregnancy and become a parent is indeed fundamental, and no free society should allocate it exclusively to the state, as the following sections elaborate.[2]

A. Reproductive Choice Is Essential to a Woman's Control of Her Destiny and Family Life.

This Court has long acknowledged an unenumerated right to privacy as a species of "liberty" protected by the Due Process Clauses.[3] The principle is as venerable as *Meyer v. Nebraska*, 262 U.S. 390 (1923), and *Pierce v. Society of Sisters*, 268 U.S. 510 (1925), both of which protected parents' freedom to educate their children as they chose, free of the controlling hand of the state. In its modern elaboration, this right has continued to protect matters of child-rearing and family life from the overly

1 *Webster v. Reproductive Health Serv.*, 109 S. Ct. 3040 (1989), while upholding several abortion regulations, in no way overruled *Roe*. As Chief Justice Rehnquist wrote for the plurality, "This case . . . affords us no occasion to revisit the holding of *Roe*, which was that the Texas statute unconstitutionally infringed the right to an abortion derived from the Due Process Clause . . . and we leave it undisturbed." *Id.* at 3058; *see also id.* at 3061 (O'Connor, J., concurring in part and concurring in judgment).

2 Only three current members of this Court have ever disputed *Roe*'s premise that a woman's right to control pregnancy is fundamental. *See Roe*, 410 U.S. at 172-78 (Rehnquist, J., dissenting); *Doe v. Bolton*, 410 U.S. 179, 221-23 (1973) (White, J., dissenting); *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 785-97 (1986) (White, J., dissenting); *Webster*, 109 S. Ct. at 3064 (Scalia, J., concurring in part and concurring in judgment).

3 Recognition of the right of privacy is only one among many instances in which this Court has recognized constitutional rights that are not expressly named in the text of the Constitution. To name but a few other examples, this Court has recognized unenumerated rights to freedom of association, *see NAACP v. Alabama*, 357 U.S. 449 (1958); to equal protection under the Fifth Amendment Due Process Clause, *see Bolling v. Sharpe*, 347 U.S. 497 (1954); to travel between the states, *see Shapiro v. Thompson*, 394 U.S. 618 (1969); to vote, *see Harper v. Virginia Bd. of Elections*, 383 U.S. 663 (1966); *Reynolds v. Sims*, 377 U.S. 533 (1964); and to attend criminal trials, *see Richmond Newspapers, Inc. v. Virginia*, 448 U.S. 555 (1980).

intrusive reach of government. *See, e.g., Moore v. City of East Cleveland*, 431 U.S. 494 (1977) (right to live with one's grandchildren); *Loving v. Virginia*, 388 U.S. 1 (1967) (right to interracial marriage). The modern privacy cases have also established that the decision whether to have children is no less fundamental than any other decision about family life. This Court has consistently held since *Griswold v. Connecticut*, 381 U.S. 479 (1965), that "matters so fundamentally affecting a person as the decision whether to bear or beget a child" are accorded special protection under the Constitution, and has therefore strictly scrutinized laws restricting contraception. *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972). *Roe v. Wade* held that these principles extend no less to abortion.

The privacy line of cases rests centrally on " 'the moral fact that a person belongs to himself [or herself] and not others nor to society as a whole.' " *Thornburgh*, 476 U.S. at 777 n.5 (Stevens, J., concurring) (quoting former Solicitor General Fried, *Correspondence*, 6 Phil. & Pub. Aff. 288-89 (1977)). And the application of this principle to the abortion decision follows from the fact that "few decisions are more basic to individual dignity and autonomy" or more appropriate to the "private sphere of individual liberty" than the uniquely personal, intimate, and self-defining decision whether or not to continue a pregnancy. *Thornburgh*, 476 U.S. at 772 (majority opinion).

In two senses, abortion restrictions keep a woman from "belonging to herself." First and most obviously, they deprive her of bodily self-possession. As Chief Justice Rehnquist has observed in another context, pregnancy entails "profound physical, emotional, and psychological consequences." *Michael M. v. Sonoma County Superior Court*, 450 U.S. 464, 471 (1981). To name a few, pregnancy increases a woman's uterine size 500-1000 times, resting pulse rate by ten to fifteen beats a minute, and body weight by twenty-five pounds or more.[4] Even the healthiest pregnancy may be marked by nausea, vomiting, more frequent urination, fatigue, back pain,

4 *See* J. Pritchard, P. McDonald & N. Gant, *Williams Obstetrics* 181-210, 260-63 (17th ed. 1985).

labored breathing, or water retention.[5] The medical risks involved in carrying pregnancy to term are numerous: of every ten women who go through pregnancy and childbirth, six are treated for some medical complication, and three are treated for major complications.[6] And of course labor and delivery impose extraordinary physical demands, whether over the course of six- to twelve-hour or longer vaginal delivery, or during highly invasive surgery in the one out of four deliveries that proceed by cesarean section.[7]

By compelling pregnancy to term and delivery even when unwanted, abortion restrictions thus exert far more profound intrusions into bodily integrity than the stomach-pumping invalidated in *Rochin v. California*, 342 U.S. 165 (1952), or the surgical removal of a bullet from a shoulder invalidated in *Winston v. Lee*, 470 U.S. 753 (1985). "The integrity of an individual's person is a cherished value of our society," *id.* at 760, because it is so essential to identity: "[to say] that my body can be used is [to say] that I can be used," C. Fried, *Right and Wrong* 121 n.* (1978).

These points would be too obvious to require restatement if the state were to compel abortions rather than to restrict them. Indeed, in colloquy with Justice O'Connor during the oral argument in *Webster v. Reproductive Health Service*, 109 S. Ct. 3040, former Solicitor General Fried, arguing for the United States, conceded that in such a case, liberty principles, although unenumerated, would compel the strictest review. Transcript of Oral Argument at 21-22, *Webster*. To be sure, as Mr. Fried suggested, restricting abortion does not literally involve "laying hands on a woman." *Id.* at 22. But this distinction should make no difference: the state would plainly infringe the bodily integrity of its citizens whether its agents inflicted knife wounds or

5 *Id.*

6 *See* R. Gold, A. Kenney & S. Singh, *Blessed Events and the Bottom Line: Financing Maternity Care in the United States* 10 (1987).

7 *See* D. Danforth, M. Hughey & A. Wagner, *The Complete Guide to Pregnancy* 228-31 (1983); S. Romney, M. Gray, A. Little, J. Merrill, E. Quilligan & R. Stander, *Gynecology and Obstetrics: The Health Care of Women* 626-37 (2d ed. 1981).

its laws forbade surgery or restricted blood transfusions in cases of private knifings.[8]

Apart from this impact on bodily integrity, abortion restrictions infringe a woman's autonomy in a second sense as well: they infringe the autonomy over decision-making in family affairs that this Court has long deemed central to the right of privacy. Liberty requires independence in making the most important decisions in life. *See Whalen v. Roe*, 429 U.S. 589, 599-600 (1977). "The decision whether or not to beget or bear a child" lies at "the very heart of this cluster of constitutionally protected choices," *Carey v. Population Services International*, 431 U.S. 678, 685 (1977), because few decisions can more importantly alter the course of one's life than the decision to bring a child into the world. Bearing a child dramatically affects " 'what a person is, what [s]he wants, the determination of [her] life plan, of [her] concept of the good' " and every other aspect of the " 'self-determination [that] give[s] substance to the concept of liberty.' " *Thornburgh*, 476 U.S. at 777 n.5 (Stevens, J., concurring) (quoting C. Fried, *Right and Wrong* at 146-47). Becoming a parent dramatically alters a woman's educational prospects,[9] employment opportunities,[10] and sense of self.[11] In light of these elemental points, it is no surprise that the freedom to choose one's own family formations is "deeply

8 Similarly, a state would surely be prohibited from compelling abortions even if it became technologically possible to do so without "laying hands on a woman."

9 Teenage mothers have high dropout rates: eight out of ten who become mothers at age seventeen or younger do not finish high school. *See* Fielding, *Adolescent Pregnancy Revisited*, 299 Mass. Dep't Pub. Health 893, 894 (1978).

10 Control over the rate of childbirth is a key factor in explaining recent gains in women's wages relative to men's. *See* Fuchs, *Women's Quest for Economic Equality*, 3 J. Econ. Persp. 25, 36-37 (1989).

11 This is so even if the woman who bears a child does not raise that child. Relinquishing a child for adoption may alleviate material hardship but is psychologically traumatic. Winkler & VanKeppel, *Relinquishing Mothers in Adoption: Their Long-Term Adjustment* (Institute of Family Studies Monograph No. 3, 1984).

rooted in this Nation's history and tradition." *Moore v. City of East Cleveland*, 431 U.S. at 503 (plurality opinion).

These principles of decisional autonomy over childbearing are today virtually uncontroverted with respect to heightened constitutional protection for contraception.[12] But critics of *Roe* sometimes argue that abortion is "different in kind from the decision not to conceive in the first place." *Thornburgh*, 476 U.S. at 792 (White, J., dissenting). Justice White, for example, has asserted that, while the liberty interest is fundamental in the contraception context,[13] that interest falls to minimal after conception.[14]

This distinction is erroneous. For no bright line can be drawn between contraception and abortion in light of modern advances in science and medicine. Contraception and abortion are rather points on a continuum. "Conception" itself is a complex process of which fertilization of ovum by sperm is simply the first stage. According to standard contemporary medical authorities, conception begins not at the stage of fertilization, but rather six to seven days later when the fertilized egg becomes implanted in the uterine wall—which is itself a complex process.[15] Many contraceptives that are medically

12 The United States has conceded the correctness of the *Griswold* line of cases before this Court. *See* Brief for the United States as *Amicus Curiae* Supporting Appellants at 11-13, *Webster*; Transcript of Oral Argument at 20, *Webster* (argument of former Solicitor General Fried on behalf of the United States).

13 *See Griswold*, 381 U.S. at 502-03 (White, J., concurring in judgment); *Eisenstadt*, 405 U.S. at 463-64 (White, J., concurring in result).

14 *See Thornburgh*, 476 U.S. at 792-93 (White, J., dissenting) (arguing that presence of the fetus after conception changes not merely the state justification but "the characterization of the liberty interest itself").

15 *See Williams Obstetrics* at 88-91; Milby, *The New Biology and the Question of Personhood: Implications for Abortion*, 9 Am. J. Law & Med. 31, 35 (1983). Indeed, the American College of Obstetricians & Gynecologists, the preeminent authority on such matters, has adopted the following official definition of conception: conception consists of "the implantation of the blastocyst [fertilized ovum]" in the uterus, and thus is "*not* synonomous with fertilization." *Obstetric-Gynecologic Terminology* 229, 327 (E. Hughes ed. 1972) (emphasis added). Such a definition is not surprising in view of the fact that only 50% of fertilized ova ever succeed in becoming implanted. *See Post-Coital Contraception*, The Lancet, Apr. 16, 1983, at 856.

accepted today operate after fertilization. For example, both oral contraceptives and the intrauterine device (IUD) are used not only to prevent fertilization but in some instances to prevent implantation.[16] Moreover, the most significant new developments in contraceptive technology, such as RU486, act by foiling implantation.[17] All such contraceptives blur the line between contraception and abortion.

In the absence of a bright physiological line, there can be no bright constitutional line drawn between the moments before and after conception. A woman's fundamental liberty interest does not simply evaporate when sperm meets ovum. "Indeed, if one decision is more 'fundamental' to the individual's freedom than the other, surely it is the postconception decision that is the more serious." *Thornburgh*, 476 U.S. at 776 (Stevens, J., concurring). To say this much is not to deny that profound evolutionary changes occur over the period from fertilization to birth. Of course there is a difference between "the freshly fertilized egg and . . . the 9-month-gestated . . . fetus on the eve of birth." *Id.* at 779. But as *Roe v. Wade* fully recognized, such differences go at most to the weight of the state's justification for interfering with a pregnancy; they in no way extinguish the woman's underlying fundamental liberty interest.

Thus *Roe* is not a mere "thread" that could be pulled without "unravel[ing]" the now elaborately woven "fabric" of this

16 *See* Hatcher, *et al.*, *Contraceptive Technology* 252-53, 377 (1988-89 ed.); U.S. Dep't of Health & Human Services, *IUDs: Guidelines for Informed Decision-Making and Use* (1987).

17 *See Contraceptive Technology* at 393; Nieman, *et al.*, *The Progesterone Antagonist RU486: A Potential New Contraceptive Agent*, 316 New Eng. J. Med. 187 (1987). RU486 has been used in France but not yet in the United States.

Court's privacy decisions.[18] Rather, *Roe* is integral to the principle that decisions about childbearing "come to this Court with a momentum for respect that is lacking when appeal is made to liberties which derive merely from shifting economic arrangements." *Thornburgh*, 476 U.S. at 775 (Stevens, J., concurring) (citing White, J., concurring in *Griswold*, 381 U.S. at 502-03 (quoting Frankfurter, J., concurring in *Kovacs v. Cooper*, 336 U.S. 77, 95 (1949))). The decision whether to become a mother is too fundamental to be equated with the decision to buy a car, choose optometry over opthalmology, take early retirement—or any other merely economic decision that may be regulated by government on a showing of only a minimally rational basis.

B. Keeping Reproductive Choice in Private Hands Is Essential to a Free Society.

Even if there were any disagreement about what degree of bodily or decisional autonomy is essential to personhood, there is a separate, alternative rationale for the privacy cases: to keep the state out of the business of reproductive decision-making. Regimentation of reproduction is a hallmark of the totalitarian state, from Plato's *Republic* to Hitler's Germany, from Huxley's *Brave New World* to Atwood's *Handmaid's Tale*. "[T]otalitarian limitation of family size . . . is at complete variance with our constitutional concepts." *Griswold*, 381 U.S. at 497 (Goldberg, J., concurring). This is so whether the state compels reproduction or prevents it. For the state's monopoly of power cautions against *any* official reproductive orthodoxy.

This Court has long recognized that, for these reasons, the right of privacy protects not only the individual but also our society. As early as the decisions in *Meyer* and *Pierce*, the Court acknowledged that "[t]he fundamental theory of liberty" on which a free society rests "excludes any general power of the State to standardize" its citizens. *Pierce*, 268 U.S. at 535. As

18 Transcript of Oral Argument at 19, *Webster* (argument of former Solicitor General Fried on behalf of the United States). Counsel for Appellees gave the following complete reply: "It has always been my personal experience that when I pull a thread, my sleeve falls off." *Id.* at 26 (argument of Frank Susman).

Justice Powell likewise recognized for the plurality in *Moore*, " 'a free society' " is one that avoids the homogenization of family life. *See Moore*, 431 U.S. at 503 n.11. The right of privacy, like freedoms of speech and religion, protects conscience and spirit from the encroachment of overbearing government. As Justice Jackson stated in *West Virginia State Board of Education v. Barnette*, 319 U.S. 624, 640-41 (1943), "[s]truggles to coerce uniformity of sentiment" are the inevitably futile province of "our totalitarian enemies." Preserving a private sphere for decision-making in matters of childbearing and rearing thus not only liberates the individual; it desirably constrains the state.[19]

Those who would relegate all control over abortion to the state legislatures ignore these fundamental systemic values. It is a red herring to focus on the question of judicial versus legislative control of reproductive decisions, as so many of *Roe*'s critics do; the real distinction is that between private and public control of that decision—the private control protected by the courts in *Griswold* and *Roe*, and the public control that the popular branches could well usurp in a world without those decisions.

Precisely because of the importance of a private sphere for family, spirit, and conscience, the Framers never intended that all issues on which moral disagreement exists be committed to the political arena. Quite the contrary,

> The very purpose of a Bill of Rights was to withdraw certain subjects from the vicissitudes of political controversy, to place them beyond the reach of majorities and officials and to establish them as legal principles to be applied by the courts. One's right to life, liberty and property, to free speech, a free press, freedom of worship and assembly, and other fundamental rights may not be submitted to vote; they depend on the outcome of no elections . . . .

19 *See generally* Rubenfeld, *The Right of Privacy*, 102 Harv. L. Rev. 737 (1989) (arguing that the constitutional right of privacy protects individuals from being turned into instrumentalities of the regimenting state, or being forced into an identity of the state's choosing).

West Virginia State Board of Education v. Barnette, 319 U.S. at 638. Such "withdrawal" of fundamental liberties from the political arena is basic to a system of *constitutional* democracy, as opposed to rank majoritarianism. And nowhere is such "withdrawal" more important than in controversies where moral convictions and passions run deepest—as the inclusion of the Free Exercise Clause attests.[20]

Nor did the Framers ever intend that toleration on matters of family, conscience, and spirit would vary from state to state. The value of the states and localities as "laborator[ies for] social and economic experiments," *New State Ice Co. v. Liebman*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting), has never extended to " 'experiments at the expense of the dignity and personality' of the individual." *Poe v. Ullman*, 367 U.S. 497, 555 (1961) (Harlan, J., dissenting) (quoting *Skinner v. Oklahoma*, 316 U.S. 535, 546 (1942) (Jackson, J., concurring)). Rather, as Madison once warned, " '[I]t is proper to take alarm at the first experiment on our liberties. We hold this prudent jealousy to be the first duty of citizens, and one of the noblest characteristics of the late Revolution.' " *Everson v. Board of Education*, 330 U.S. 1, 65 (1947) (Appendix, Rutledge, J., dissenting) (quoting Madison, *Memorial and Remonstrance Against Religious Assessments*).

Roe v. Wade thus properly withdrew the abortion decision, like other decisions on matters of conscience, "from the vicissitudes of political controversy." It did not withdraw that decision from the vicissitudes of moral argument or social suasion

20 "The Fathers of the Constitution were not unaware of the varied and extreme views of religious sects, of the violence of disagreement among them and of the lack of any one religious creed on which all men would agree. They fashioned a charter of government which envisaged the widest possible toleration of conflicting views." *United States v. Ballard*, 322 U.S. 78, 87 (1944). Indeed, so clear is this principle that the Free Exercise Clause may afford a separate and alternative constitutional basis for the rights protected in *Roe*. *See generally* Brief *Amicus Curiae* for American Jewish Congress, *et al.*, *Webster*; *see also Webster*, 109 S. Ct. at 3085 & n.16 (Stevens, J., dissenting) (noting that "the intensely divisive character of much of the national debate over the abortion issue reflects the deeply held religious convictions of many participants in the debate").

by persuasive rather than coercive means.[21] In withdrawing the abortion decision from the hot lights of politics to the private sphere, *Roe* protected not only persons but the processes of constitutional democracy.

II. EVEN IF CONSTITUTIONAL PRIVACY PRINCIPLES DID NOT SO PLAINLY PROTECT THE RIGHT TO ABORTION, EQUAL PROTECTION PRINCIPLES WOULD DO SO.

Roe was correctly decided on a privacy rationale, and the Court need look no further before reaffirming that decision. But if *Roe*'s privacy foundation should ever be eroded, there exists a separate, alternative constitutional basis for reviewing restrictive abortion laws closely as *Roe* did: namely, the Equal Protection Clause. Because abortion restrictions both discriminate uniquely against women, and do so in a way that intrudes on women's basic interests in bodily integrity, procreation, and health, such laws should trigger strict scrutiny.

A. Sex Classifications that Interfere with Bodily Integrity and Procreation Are Impermissible in the Absence of Compelling Justification.

This Court has held that measures classifying on the basis of gender are unconstitutional unless the party suppporting the measure can "carry the burden of showing an 'exceedingly persuasive justification' for the classification." *Mississippi University for Women v. Hogan*, 458 U.S. 718, 724 (1982) (quoting *Kirchberg v. Feenstra*, 450 U.S. 455, 461 (1981)).[22] A "searching analysis" is required because gender-based measures often

21 Nor, of course, did it bar even political efforts to reduce the abortion rate through noncoercive means—such as by funding sex education and contraception, and providing economic security to indigent mothers.

22 Indeed, because gender-based classifications discriminate on the basis of an immutable characteristic that has long been the predicate for social disadvantage, nothing should bar this Court from going further and declaring that "classifications based upon gender are inherently suspect" and thus trigger the strictest scrutiny—a question expressly left open in *Mississippi University for Women*, 458 U.S. at 724 n.9; *see Frontiero v. Richardson*, 411 U.S. 677, 688 (1973) (plurality opinion).

reflect the "mechanical application," *Mississippi University for Women*, 458 U.S. at 726, of " 'old notions' and 'archaic and overbroad' generalizations," *Califano v. Goldfarb*, 430 U.S. 199, 211 (1977) (plurality opinion) (quoting *Stanton v. Stanton*, 421 U.S. 7, 14 (1975) and *Schlesinger v. Ballard*, 419 U.S. 498, 508 (1975)), and operate to "put women not on a pedestal, but in a cage." *Frontiero v. Richardson*, 411 U.S. at 684 (plurality opinion). Thus, this Court has repeatedly struck down legislation that restricted the exercise by both men and women of liberty in social roles, recognizing that "[n]o longer is the female destined solely for the home and the rearing of family, and only the male for the marketplace and the world of ideas." *Stanton v. Stanton*, 421 U.S. at 14. *See also Weinberger v. Wiesenfeld*, 420 U.S. 636 (1975); *Mississippi University for Women*, 458 U.S. at 726 (heightened scrutiny serves to eliminate "fixed notions concerning the roles and abilities of males and females").[23]

Exacting as it is, this scrutiny escalates to the highest level where, as here, legislation that discriminates on the basis of gender also intrudes on basic interests in bodily integrity, procreation, health, family, and sometimes life itself. The "fundamental rights" branch of equal protection jurisprudence makes clear that, where legislation classifies with respect to such basic interests, any deference that would otherwise be given the legislature attenuates. Rather, such legislation may be upheld only if it survives the strictest and most searching kind of review. Thus, in *Skinner v. Oklahoma*, 316 U.S. 535, this Court applied strict scrutiny under the Equal Protection Clause to a compulsory sterilization law that discriminated among categories of thieves—a kind of line-drawing that otherwise would not have been suspect. Likewise, in *Zablocki v. Redhail*, 434 U.S. 374

23 The fact that an equal protection argument along these lines was not advanced in *Roe* itself is plainly explained in historical terms. At the time *Roe* was decided, this body of law was in its earliest stages: *Reed v. Reed*, 404 U.S. 71 (1971), the precursor to all of these decisions, was not decided until six months *after* the Court noted probable jurisidiction in *Roe*, *see* 402 U.S. 941 (1971); and in any event, *Reed* used the language of "rational relationship" review, rather than the heightened level of scrutiny that the Court has subsequently enforced.

(1978), the Court applied strict scrutiny under the Equal Protection Clause to a marriage restriction that discriminated against persons with outstanding child support obligations—again, a classification that would normally have been deferentially reviewed. If cases such as *Skinner* and *Zablocki* treat impact on the fundamental rights to procreate and to marry as escalating the standard of review from minimal to strict, then surely the impingement of abortion laws on procreation, health, marriage, and family interests should escalate judicial scrutiny the lesser distance from heightened to strict review. Thus, the gender-based discrimination worked by restrictive abortion laws should be reviewed strictly.

B. Restrictive Abortion Laws Classify on the Basis of Sex.

The direct impact of abortion restrictions falls, exclusively, on a class of people that consists *only* of women. Only women get pregnant; only women have abortions; only women will be forced to endure unwanted pregnancies and adverse health consequences if abortions are restricted; only women are injured by dangerous, illegal abortions where legal ones are unavailable; and only women will bear children if abortions are unavailable. *See Michael M. v. Sonoma County Superior Court*, 450 U.S. at 473 ("[V]irtually all of the significant harmful and inescapable identifiable consequences of teenage pregnancy fall on the young female.").

The fact that the laws do not mention "women" is irrelevant. A law restricting "all abortions" is the precise equivalent of a law restricting "all abortions sought by women."[24] A classification based on pregnancy is, by biological definition, a classification based on gender.[25]

24 This is an instance not of disproportionate impact but of exclusive impact. In *Personnel Administrator v. Feeney*, 442 U.S. 256 (1979), by contrast, the veterans' preference upheld by this Court disadvantaged a class that was not defined, as this one is, by a biological correlate of gender. As a result, although the classification disproportionately disadvantaged women, many men were also disadvantaged. *Id.* at 281 (Stevens, J., concurring).

25 *Geduldig v. Aiello*, 417 U.S. 484 (1974), to the extent that it suggests the contrary, is not controlling. *Geduldig* sustained the constitutionality of a

Moreover, abortion restrictions, like the most classic gender-based restrictions on women seeking to participate in the worlds of work and ideas, have historically rested on archaic stereotypes of women as persons whose "paramount destiny and mission . . . [is] to fulfill the noble and benign office of wife and mother." *Bradwell v. Illinois*, 16 Wall. 130, 142 (1873) (Bradley, J., concurring). Legislation prohibiting abortion, largely a

state disability insurance program that excluded from coverage certain disabilities resulting from pregnancy. In an opinion largely devoted to the insurance justifications for excluding pregnancy, the Court, in a footnote, cursorily rejected the view that excluding "pregnant women" from benefits accruing to "nonpregnant persons" constituted sex discrimination, for the beneficiaries "include[d] members of both sexes." *Id.* at 496 n.20.

Geduldig's force today is questionable, for it reflected a very early stage in the development of equal protection law governing gender discrimination, and its reasoning has since been rejected by Congress, *see* Pregnancy Discrimination Act of 1978, Pub. L. No. 95-555, 92 Stat. 2076 (amending 42 U.S.C. § 2000e), attacked widely by commentators, *see* Law, *Rethinking Sex and the Constitution*, 132 U. Penn. L. Rev. 955, 984 nn.107-09 (1984) (collecting citations), and implicitly rejected by the line of subsequent decisions that treat laws as sex classifications even if they burden some but not all men, or some but not all women, *see, e.g., Califano v. Goldfarb*, 430 U.S. 199; *Weinberger v. Wiesenfeld*, 420 U.S. 636.

But even if *Geduldig* is still good law, the program it upheld is distinguishable from laws restricting abortion. Now-Chief Justice Rehnquist, writing for the Court in an analogous context in *Nashville Gas Co. v. Satty*, 434 U.S. 136, 142 (1977) (deeming exclusion of pregnant employees sex discrimination under Title VII), established a distinction between "merely refus[ing] to extend to women a benefit that men cannot and do not receive," and "impos[ing] on women a substantial burden that men need not suffer." Like "depriv[ing female employees] of employment opportunities because of their different role [i.e., capacity to become pregnant]," abortion restrictions constitute an affirmative "burden," not an omission to extend a benefit as was the case in *Geduldig*. *Id.* (expressly distinguishing *Geduldig*'s Title VII analogue, *General Electric Co. v. Gilbert*, 429 U.S. 125 (1976)); *cf. Cleveland Bd. of Educ. v. LaFleur*, 414 U.S. 632 (1974) (invalidating under the Due Process Clause a school board regulation that required pregnant school teachers to take unpaid maternity leave five months before childbirth); *see id.* at 652 (Powell, J., concurring on equal protection grounds). Where a law imposes affirmative burdens on pregnant women alone, *Geduldig* thus should have no force. Abortion restrictions constitute sex-based classifications no less than would laws barring all pregnant women from appearing in public.

product of the years between 1860 and 1880, reflected *precisely* the same ideas about the natural and proper role of women as did the legislation of the same period—long-since discredited—that prohibited women from serving on juries or participating in the professions, including the practice of law.[26]

Perhaps not surprisingly, modern studies have found that support for laws banning abortion continues to be an outgrowth of the same sort of stereotypical notions that women's only appropriate roles are those of mother and housewife; in many cases, such laws have emerged as a direct reaction to the increasing number of women who work outside the home. *See generally* K. Luker, *Abortion and the Politics of Motherhood* 192-215 (1984); Luker, *Abortion and the Meaning of Life*, in *Abortion: Understanding Differences* 25 (S. Callahan & D. Callahan eds. 1984).[27] It is, of course, precisely such stereotypes, as they are reflected in legislation, that have over and over again been the focus of this Court's modern equal protection cases. *See, e.g., Frontiero v. Richardson*, 411 U.S. at 684; *Stan-*

26 *See, e.g.*, J. Mohr, *Abortion in America: The Origins and Evolution of National Policy, 1800-1900* 168-72 (1978). To many of the doctors who were largely responsible for the passage of abortion restrictions, "the chief purpose of women was to produce children; anything that interfered with that purpose, or allowed women to 'indulge' themselves in less important activities, threatened . . . the future of society itself." *Id.* at 169. The view of one such nineteenth century doctor drew the parallel even more explicitly: he complained that "the tendency to force women into men's places" was creating the insidious new idea that a woman's "ministrations . . . as a mother should be abandoned for the sterner rights of voting and law making." *Id.* at 105. *See generally* Brief of 281 American Historians as *Amici Curiae* Supporting Appellees at 17-20, *Webster*; *see also* L. Gordon, *Women's Body, Women's Right: A Social History of Birth Control in America* (1976).

27 Those involved in anti-abortion activities tend to echo the views of Justice Bradley in *Bradwell*: "that men and women, as a result of . . . intrinsic differences, have different roles to play. Men are best suited to the public world of work, whereas women are best suited to rearing children, managing homes, and loving and caring for husbands. . . . Mothering, in their view, is itself a full-time job, and any woman who cannot commit herself fully to mothering should eschew it entirely." Luker, *Abortion and the Meaning of Life*, at 31.

ton v. Stanton, 423 U.S. 7; *Weinberger v. Wiesenfeld*, 420 U.S. 636; *Califano v. Goldfarb*, 430 U.S. 199.

C. The Political Process Is Inadequate to Protect Access to Abortion for All Women.

"The Framers of the Constitution knew, and we should not forget today, that there is no more effective practical guaranty against arbitrary and unreasonable government than to require that the principles of law which officials would impose upon a minority must be imposed generally." *Railway Express Agency v. New York*, 336 U.S. 106, 112 (1949) (Jackson, J., concurring). This Court has long interpreted the Equal Protection Clause to require even-handedness in legislation, lest the powerful few too casually trade away for others key liberties that they are careful to reserve for themselves. For example, the Court once struck down under the Equal Protection Clause a law permitting castration of recidivist chicken thieves but sparing white-collar embezzlers the knife. *Skinner v. Oklahoma*, 316 U.S. 535. The implication of *Skinner* was that, put to an all-or-nothing choice, legislators would rather sterilize no one than jeopardize people like themselves. Thus equality serves as a backstop to liberty. *See id.* at 546 (Jackson, J., concurring) ("There are limits to the extent to which a legislatively represented majority may conduct biological experiments at the expense of the dignity and personality and natural powers of a minority—even those who are guilty of what the majority defines as crimes.").

Every restrictive abortion law has been passed by a legislature in which men constitute a numerical majority. And every restrictive abortion law, by definition, contains an unwritten clause exempting all men from its strictures. To rely on state legislatures to protect women against "abortion regulation reminiscent of the dark ages," *Webster*, 109 S. Ct. at 3099, ignores the fact that the overwhelming majority of "those who serve in such bodies," *id.*, like the Oklahoma legislators who supported sterilization for workingmen's crimes, are not directly affected *at all* by the penalties they are imposing. It is precisely in such cases that strict scrutiny is required, to protect against the very

real danger that those in power will too casually impose burdens on others, in this case on women, that they would not have imposed upon themselves.

That is particularly so where, as here, the women most likely to be affected are those whom the political process protects least well. A world without *Roe* will not be a world without abortion, but a world in which abortion is accessible according to one's constitutional caste. While affluent women will travel to jurisdictions where safe and legal abortion is available, paying whatever is required, restrictive abortion laws—and, with them, the life-threatening prospect of the back-alley abortion—will disproportionately descend upon "those without . . . adequate resources" to avoid them. *Griswold*, 381 U.S. at 503 (White, J., concurring). Those for whom the burdens of an unwanted pregnancy may be the most crushing—the young, the poor, women whose color already renders them victims of discrimination—will be the ones least able to secure a safe abortion.

In the years prior to *Roe*, "'[p]oor and minority women were virtually precluded from obtaining safe, legal procedures, the overwhelming majority of which were obtained by white women in the private hospital services on psychiatric indications.'"[28] Women denied access to safe and legal abortions often had dangerous and illegal ones. Mishandled criminal abortions were, one detailed study found, the principal cause of maternal deaths in the 1960's,[29] and mortality rates for African-American women were as much as nine times higher than for

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28 Polgar & Fried, *The Bad Old Days: Clandestine Abortions Among the Poor in New York City Before Liberalization of the Abortion Law*, 8 Fam. Plan. Persp. 125 (1976). *See also* Pilpel, *The Abortion Crisis*, in *The Case for Legalized Abortion Now* 101 (Guttmacher ed. 1967) (93% of in-hospital abortions in New York State were performed on white women who were able to afford private rooms); Gold, *Therapeutic Abortions in New York: A 20 Year Review*, 55 Am. J. Pub. Health 964-65 (1965) (ratio of legal hospital abortions per live birth was five times more for white women than for women of color, and 26 times more for white women than for Puerto Rican women).

29 *See* Niswander, *Medical Abortion Practices in the United States*, in *Abortion and the Law* 53 (Smith ed. 1967).

white women.[30] In 1972, women of color accounted for sixty-four percent of the deaths associated with illegal abortions in this country.[31]

To trust the political process to protect these women is to ignore completely the lessons of history. Time and again, this Court has recognized its special duties to protect minorities whose rights can too easily be trampled by legislative majorities. For in such cases, there are no political checks: legislators can, without difficulty, "escape the political retribution that might be visited upon them if larger numbers were affected." *Railway Express*, 336 U.S. at 112-13 (Jackson, J., concurring). Or, if people like them were affected.

In sum, laws that restrict abortion discriminate on the basis of gender with respect to the most basic decisions of life itself. That alone is enough to justify strict scrutiny. And the fact that a return to a patchwork of restrictive abortion regulations would inevitably have a disproportionate impact on poor and minority women must surely trouble a Court concerned that government must serve all citizens, not just the privileged few.

III. ONLY THE MOST COMPELLING INTERESTS MAY JUSTIFY STATE INTERFERENCE WITH THE ABORTION RIGHT, AND ONLY WHERE SUCH REGULATION IS NARROWLY TAILORED TO THOSE INTERESTS.

The right to abortion is not, this Court has recognized, absolute, *Roe v. Wade*, 410 U.S. at 154—any more than the rights to free speech or to assembly or to religious freedom are absolutes. But government regulation that intrudes on the right to choose abortion, like other fundamental rights, can be justified only when necessary to serve compelling interests. *Id.* at 155; *see Kramer v. Union Free School District*, 395 U.S. 621, 627 (1969); *Shapiro v. Thompson*, 394 U.S. at 634; *Griswold v. Connecticut*, 381 U.S. at 485. Strict scrutiny need not be fatal; as Justice O'Connor reiterated for the Court last Term, for

30 *See* Gold, *Therapeutic Abortions*, 55 Am. J. Pub. Health at 964-65.

31 Cates & Rochat, *Illegal Abortions in the United States: 1972-1974*, 8 Fam. Plan. Persp. 86, 87 (1976).

example, race-based affirmative action can satisfy even the most "searching judicial inquiry" so long as government offers " 'a strong basis in evidence for its conclusion that remedial action was necessary.' " *City of Richmond v. J. A. Croson Co.*, 109 S. Ct. 706, 721, 730 (1989) (quoting *Wygant v. Jackson Board of Education*, 476 U.S. 267, 277 (1976)). But in the absence of a similarly strong and particularized showing of necessity to a compelling purpose, laws burdening the abortion right must be struck down.

In *Roe v. Wade*, this Court identified two and only two state interests that could ever furnish a justification sufficiently powerful to override a woman's fundamental right to control her body: protecting the woman's health and protecting potential life.[32] Furthermore, *Roe* required that regulations furthering these interests be "narrowly drawn," 410 U.S. at 155, and thus that "the means chosen 'fit' th[ese] compelling goal[s] so closely that there is little or no possibility that the motive" was actually something different and less powerful. *Croson*, 109 S. Ct. at 721. By applying strict scrutiny, and thus limiting the circumstances in which these state interests could be found sufficiently compelling to outweigh the woman's right, this Court in *Roe* and in succeeding cases has fulfilled its most basic responsibility as a guardian of fundamental rights.

Fair application of this Court's precedents requires application of such strict scrutiny every time that a state non-trivially limits the freedom of women to choose abortion—whether that limitation is termed a "significant obstacle," a "direct interference," or an "undue burden." And this Court's precedents further require that such regulations be invalidated whenever they impose burdens unnecessary to further any compelling state interest, as do the laws enacted by Ohio and Illinois here.

32 *Cf. Croson*, 109 S. Ct. at 721 (limiting compelling justification for race-based affirmative action to one and only one state interest: remedying past discrimination).

A. Strict Scrutiny Properly Invalidates any Abortion Regulation Not Proven Necessary to Protect the Woman's Health or to Protect Potential Life.

In *Roe v. Wade*, this Court identified two state interests that might, under certain circumstances, be sufficiently "compelling" to limit a woman's fundamental right to choose abortion. The state, the Court found, "does have an important and legitimate interest in preserving and protecting the health of the pregnant woman," and "it has still *another* important and legitimate interest in protecting the potentiality of human life." 410 U.S. at 112.

But the mere invocation of these interests, at any time and for any purpose, is not enough to sustain state regulation. Quite the contrary, as Justice O'Connor recently stated for the Court in *Croson*, "the mere recitation of a 'benign' or legitimate purpose" is not enough when infringement of fundamental rights is at stake; under strict scrutiny, "simple legislative assurances of good intention cannot suffice." 109 S. Ct. at 724 (rejecting city council's general assertion of remedial purpose as inadequate to defend a minority business set-aside). It is not enough merely to assert an interest—in this case, protecting the woman's health or protecting potential life—that might in some cases be sufficiently "compelling" to survive strict scrutiny. Rather, under the exacting inquiry required by strict scrutiny, a court must evaluate how the government seeks to further that interest—specifically, whether regulations are narrowly tailored to serve the asserted compelling goals, and whether those goals were in fact the actual motivation for the regulation.

In *Roe*, the Court established a framework for applying this analysis that has fairly guided its decisions on abortion in the years since 1973. So long as abortion poses a smaller risk to the health of the woman than childbirth, the state cannot claim that a regulation of abortion is narrowly tailored to a compelling interest in protecting the woman's health and safety. 410 U.S. at 163. And until the point of "viability," when a fetus has the theoretical capacity for meaningful life outside the womb, the

state interest in potential life is not sufficiently compelling to justify restricting the woman's right to abortion. *Id.* at 163-64.[33]

Roe's trimester analysis provided a shorthand for evaluating precisely these balances. Until the end of the first trimester, mortality in abortion was less than mortality in normal childbirth; thus, only after that point, the Court held, was the state permitted to enforce regulations of the abortion procedure for the purpose of preserving the woman's health. And until the point of "viability"—between twenty-four and twenty-eight weeks when *Roe* was decided—the state's interest in preserving potential life was, the Court held, biologically and logically secondary to the woman's right to terminate her pregnancy.[34]

The *Roe* framework represents a fair balancing between the competing interests of the woman and the state. To hold that the state *never* has a compelling interest would make the abortion right different from other constitutional rights, none of which is absolute. But to hold that a state interest in potential life is equally compelling *throughout* pregnancy would leave a woman with no protection at all, and would make an utter mockery of the Court's recognition that the right to choose abortion is a protected liberty interest. Any regulation, even criminal prohibition, could then be justified by reference to this "compelling" state interest. Such a test would replace strict scrutiny with no scrutiny at all. Indeed, this was precisely how

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33 Even after viability, however, the state cannot proscribe abortion "when it is necessary to preserve the life and health of the mother." *Roe v. Wade*, 410 U.S. at 164.

34 Contrary to the claims of critics of the trimester approach, such an effort to create administrable shorthands for applying complex balances is standard constitutional practice. The First Amendment's protection of "speech," for example, no more tells judges to trifurcate public property into "public forums," "limited public forums," and "nonpublic forums," *see Perry Educ. Ass'n v. Perry Local Educators' Ass'n*, 460 U.S. 37 (1983) (per White, J.), than the Fourteenth Amendment's protection of "liberty" commands, or precludes, the trifurcation of pregnancy. The fact that *Roe* necessitates line-drawing likewise distinguishes it not at all from the myriad of rules relating to books, buses, teachers, and classrooms that has emerged to define the constitutional prohibition of establishment of religion. Yet one

Texas sought to justify the criminal prohibitions at issue in *Roe* itself. *See* 410 U.S. at 159. The balance struck by the Court, by contrast, has served in succeeding cases to " 'smoke out' " regulations that fit a stated health goal or interest in potential life too loosely to survive appropriately "searching judicial inquiry." *Croson*, 109 S. Ct. at 721.

The *Roe* framework has been not only sound in principle, but workable in practice. Changes in technology may occur, but are no reason to revise the standard of review established in *Roe*. For example, in *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 435-36 (1983), the Court invalidated a second-trimester hospitalization requirement because changing medical technology had made early second-trimester abortions as safe as first-trimester abortions. The hospitalization requirement was not, therefore, narrowly tailored to promote women's health. To the extent that changes occur,[35] the solution is not the abandonment of *Roe*, any more than the invention of the telephone counseled abandonment of fourth amendment doctrines protecting "papers and effects." Rather, the solution must come in the accommodation of *Roe*'s core principles to changed circumstances.

To be sure, in the case of abortion, the Court's line-drawing proceeds in a climate of sharp political divisions across the

would be hard pressed to argue that strict scrutiny ought to be abandoned in first amendment cases because difficult lines must repeatedly be drawn.

35 No change in technology has affected the boundary between the second and third trimesters. Notwithstanding criticism, *Roe*'s viability line has remained a relatively stable one. "Neonates less than 24 weeks gestational age [the earliest point cited in *Roe*] have close to a 0% survival rate. . . . [B]efore [the occurrence of the fixed biological threshold], the fetal organs, especially the lungs, are not sufficiently developed to permit extrauterine survival even with the most sophisticated technology currently available." *Fetal Extrauterine Survivability*, Report to the New York Task Force on Life and Law 3, 12 (1988). *See also* Law, *Rethinking Sex and the Constitution*, 132 U. Pa. L. Rev. at 1023-24 & n.245; Coulthard, *Maturation of Glomerular Filtration in Preterm and Mature Babies*, 11 Early Hum. Dev. 281-85 (1985); Hallman, *et al.*, *Exogenous Human Surfactant for Treatment of Severe Respiratory Distress Syndrome: A Randomized Prospective Clinical*, 106 J. Pediatry 963 (1985); K. Moore, *The Developing Human* 224 (1982).

nation. And under the tests articulated in *Roe*, the Court's competence to draw lines may sometimes seem challenged by medical and scientific developments. But that is the result of choices made not in 1973 when *Roe* was decided, but two centuries ago, in establishing our form of government:

> [O]ur duty to apply the Bill of Rights [does not] depend upon our possession of marked competence in the field where the invasion of rights occurs. . . . [W]e act in these matters not by authority of our competence but by force of our commissions. We cannot, because of modest estimates of our competence . . . withhold the judgment that history authenticates as the function of this Court when liberty is infringed.

West Virginia Board of Education v. Barnette, 319 U.S. at 638-40.

B. Any Significant Regulatory Interference with the Abortion Right Triggers Strict Scrutiny.

The strict scrutiny required by *Roe v. Wade* must be applied whenever the abortion right is infringed. This Court has consistently applied strict scrutiny not only when abortion is criminalized, *see Roe v. Wade*, but also whenever regulations short of criminalization encumber it with significant delay, administrative hurdles, or expense. The only times this Court has applied lesser scrutiny are when government proceeds not by act but by omission: for example, when government decides to provide funds to poor women for childbirth, but not for abortion. *See Harris v. McRae*, 448 U.S. 297 (1980); *Maher v. Roe*, 432 U.S. 464 (1977).[36] But nothing in those cases so much

36 In those cases, this Court held that omitting to subsidize abortion with public resources was a mere denial of benefits, not a governmentally imposed burden on a woman's fundamental right to choose abortion. The Court therefore upheld such selective subsidies on mere rational-basis review. *See Harris*, 448 U.S. at 325 (state action "encouraging childbirth except in the most urgent circumstances" held "rationally related to the legitimate governmental objective of protecting potential life").

as suggested that government has similar license when it would affirmatively burden a woman's choice. This Court's precedents make clear that, while it is one thing selectively to subsidize childbirth but not abortion, it is quite another affirmatively to tax, penalize, or deter that choice by regulatory means.

Where such regulatory interference is present, it does not matter what it is called. This Court has sometimes termed such interference "direct" or "significant" in order to clarify that the heavy artillery of strict scrutiny need not be called forth in instances of merely trivial or *de minimis* effect. Justice O'Connor has expressed a preference for the term "undue burden" to capture the very same concept.[37] The nomenclature is unimportant; what matters is that strict scrutiny be applied to all burdens that are significant by any name.

In identifying such burdens, whether they are termed "significant" or "undue," several principles are clear from this Court's precedents. First, it is not necessary that *all* women be burdened for a regulation to trigger strict scrutiny. While the legislation invalidated in *Roe*, for example, obviously constituted a significant interference or undue burden because it

37 In dissent in *Akron v. Akron Center for Reproductive Health*, Justice O'Connor argued that this Court's abortion cases should be read to require strict scrutiny only where the State imposes what she termed an "undue burden" on the abortion decision. 462 U.S. at 464-65. But as Justice O'Connor's own articulations make clear, inquiry into "undue burden" is simply a threshold inquiry into the quantity of the burden imposed. It serves to shield from the strictest scrutiny regulations whose actual impact on the abortion decision is trivial, or speculative, or both. The measure of whether a burden is "undue" is not whether it is justified, but whether it is significant.

Justice O'Connor herself could hardly have been clearer that the threshold "undue burden" inquiry is purely quantitative, not qualitative. For example, Justice O'Connor vigorously and explicitly rejected the United States' suggestion, in the *Akron* case, that the Court should "accord heavy deference to the legislative judgment" in determining what constitutes an "undue burden." Quite the contrary, she wrote, "[I]t is not appropriate to *weigh* the state interests at the threshold stage." *Id.* at 465 n.10.

Justice O'Connor has likewise been clear that once what she terms an "undue burden" has been found, the "exacting standard" of strict scrutiny is triggered—not some lesser standard of review. *See Akron, id.* at 463 (O'Connor, J., dissenting).

criminalized all abortions except those necessary to save the life of the mother, the prohibition of saline amniocentesis struck down in *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976), also constituted such an interference or burden—even though this burden was limited to women seeking second trimester abortions and notwithstanding that the overwhelming majority of abortions are performed in the first trimester. The same was true for the requirements of parents' or husbands' consent invalidated in *Danforth* and *Bellotti v. Baird*, 443 U.S. 622 (1979): these regulations were subject to strict scrutiny even though they would impose an "absolute obstacle" only to that narrow group of women who were both covered by the regulations (minors or married) and also unable to secure the requisite consent.[38] These holdings are sound, for the right recognized in *Roe* is a right possessed by every pregnant woman; a regulation that "drastically limits" the freedom of even one woman should trigger strict scrutiny. And surely if the regulation, by purpose or effect, imposes "coercive restraints" on the choice of a group of women—unfortunately, too often, those most vulnerable because of their age or their poverty or their race—then it should be no answer that older women, or richer women, or white women who live in cities are not really burdened at all.

Second, it is clear that the question whether a "significant interference" or "undue burden" is imposed must be considered from the perspective of the woman who is burdened. Because what matters is the obstacle facing the woman who is making the abortion decision, the only appropriate perspective from which the burden can be assessed is hers. *Cf. Lynch v. Donnelly*, 465 U.S. 668, 690 (1984) (O'Connor, J., concurring). The question is not whether a judge or a legislator or the law's perennial "reasonable man" would judge an increase in cost or a requirement of notification to be an "absolute obstacle;" the question is whether a pregnant woman, or girl, would. If burdens are to be assessed fairly, they can only be assessed from the

38 Justice O'Connor admits that these regulations constitute "undue burdens," notwithstanding the limitation of their impact to these relatively narrow groups of women. *See Akron*, 462 U.S. at 464 (O'Connor, J., dissenting).

perspective of the one who is, usually intentionally, being burdened.

This is not simply a question of a man's perspective versus a woman's, or, all too often, a girl's. It is not even simply a question of the comfortable versus, all too often, the poor and the desperate. Justice O'Connor recognized in *Akron* that the abortion decision is a " 'stressful one.' " 462 U.S. at 474 (O'Connor, J., dissenting) (quoting *Planned Parenthood v. Danforth*, 428 U.S. at 67). That recognition is reason to weigh all the more carefully any additional burden the state seeks to impose.

Finally, to assess the burden of an entire statutory scheme one provision at a time is plainly inconsistent with taking the proper perspective. Provisions that are not "significant obstacles" or "undue burdens" taken one by one are not experienced that way by the woman who may be subject to all of them.

Assessed according to these basic definitional principles, the regulatory schemes enacted by Ohio and Illinois in these cases are plainly subject to strict scrutiny, whether their impact on women is termed "significant" or simply "undue." And by that exacting standard, there can be no doubt they must fall.[39]

39 *Amici* leave detailed argument on these points to the Briefs of the Appellees in *Turnock v. Ragsdale* and *Ohio v. Akron Center for Reproductive Health*. That this brief is not filed in *Hodgson v. Minnesota*, 853 F.2d 1452 (8th Cir. 1988) (en banc), *cert. granted*, 109 S. Ct. 3240 (1989) (Nos. 88-1125, 88-1309), reflects only the constraints of briefing schedules.

CONCLUSION

For these reasons, *amici* respectfully request that this Court reaffirm *Roe v. Wade* and affirm the judgments below in *Turnock v. Ragsdale* and *Ohio v. Akron Center for Reproductive Health*.

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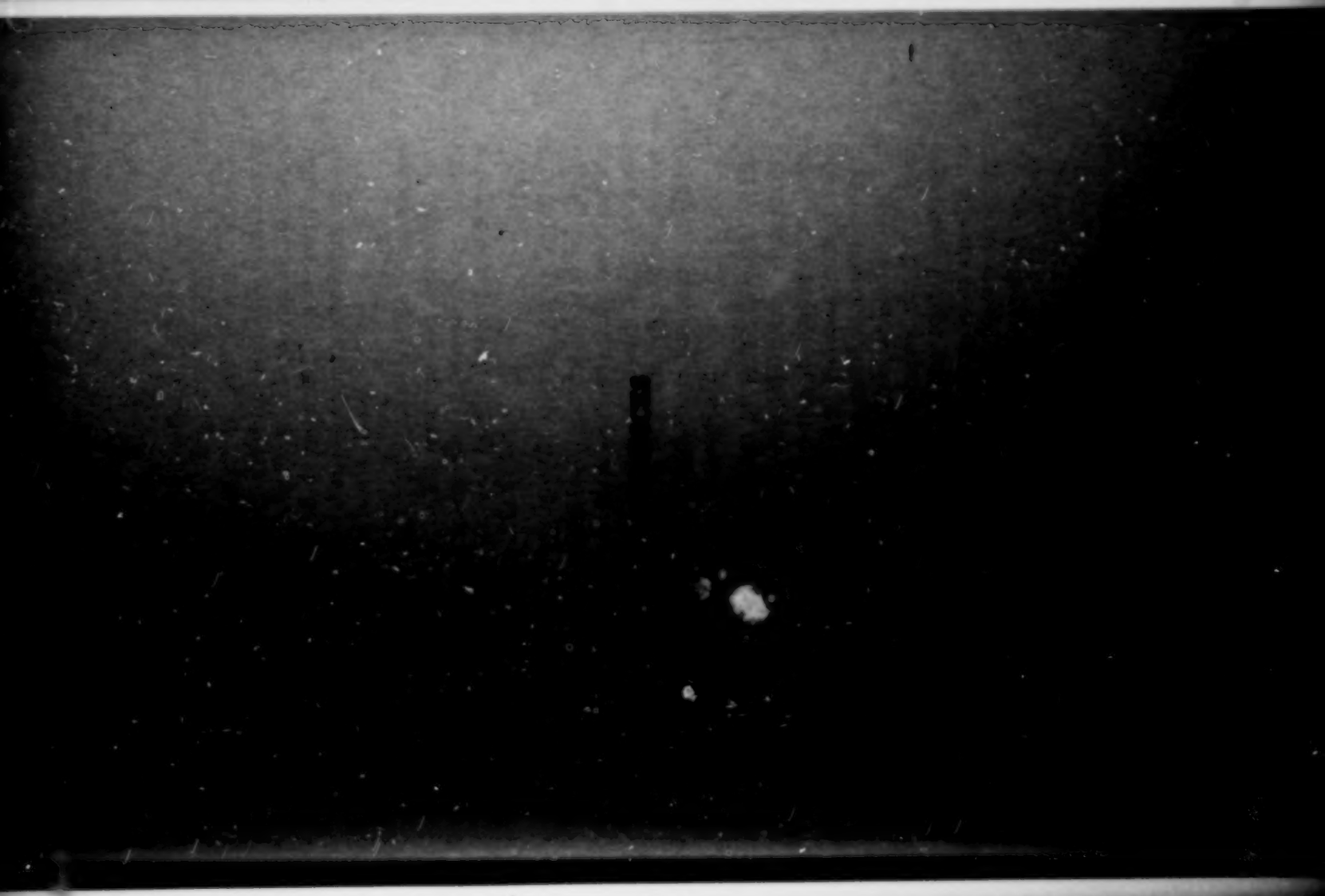

APPENDIX A

ABORTION RIGHTS COUNCIL (ARC)* was founded in 1968 and currently has 5000 members and 12,000 supporters in the State of Minnesota. It has as its sole purpose keeping abortions safe and legal for all women. ARC opposes any further restrictions on women's access to abortions and supports the principles established in *Roe* v. *Wade*.

ABORTION RIGHTS MOBILIZATION (ARM)* is a Section 501(c)(3) organization, which uses lawsuits, education, and other techniques "to implement and guarantee a woman's right to legal abortion as decreed by the United States Supreme Court," following ARM's bylaws.

AD HOC COMMITTEE OF 367 AMERICAN HISTORIANS is a group of professional historians who, from widely diverse perspectives and knowledge, are united in their conviction that *Roe* v. *Wade* is essential to women's liberty and equality and consistent with the most noble and enduring understanding of American history and traditions. Individual members of this Committee are set forth at Appendix B.

AD HOC COMMITTEE OF 491 SCIENTISTS AND PHYSICIANS is a group of distinguished scientists and physicians with advanced training and expertise in, among other fields, developmental biology, neurobiology, molecular biology, cellular biology, and obstetrics and gynecology. *Amici* have been recognized for their contributions to their respective fields. For example, thirty-one of them have received the Nobel Prize. *Amici* have a unique interest in seeing that scientific learning is not distorted or misused in arguments concerning abortion and therefore join in this brief supporting appellees. Individual members of this Committee are set forth at Appendix D.

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* Some *amici* have filed another *amicus* brief in *Ohio* v. *Akron Center for Reproductive Health*. *Amici* denoted by a single asterisk join this brief on behalf of appellees in the case of *Turnock* v. *Ragsdale*. A single asterisk will so indicate throughout this Appendix.

AD HOC COMMITTEE OF 497 AMERICAN LAW PROFESSORS includes law professors from institutions all over the United States who believe that the right of a woman to choose whether or not to bear a child, as delineated by this Court in *Roe* v. *Wade*, is an essential component of constitutional liberty and privacy commanding reaffirmation by this Court. They join this brief to underscore their belief in the fundamental importance of the right of privacy within the constitutional system and the centrality of reproductive freedom within that right. Individual members of this Committee are set forth at Appendix C.

AD HOC COMMITTEE OF 166 STATE LEGISLATORS is comprised of Representatives and Senators from thirty-two states who are united in the belief that it is a unique function of the judiciary to define and preserve individual rights. As legislators, *amici* depend upon the Supreme Court to delineate the constitutional boundaries within which to legislate. *Amici* join this brief steadfast in the conviction that identifying and defining the scope of constitutional protection for fundamental rights is the role of the judiciary, and not that of elected officials. Individual members of this Committee are set forth at Appendix E.

THE AFRICAN AMERICAN SUMMIT was created in 1989 to provide a forum to bring together African American leaders and grass roots people from throughout the nation to develop strategies and policies designed to promote the needs of and to address the major social and economic problems now facing African Americans, including the crucial issues of crime, drugs, abortion, and education. It monitors, evaluates, and disseminates information concerning contemplated, proposed, and existing legislation and policy which affects or could affect the interests of African Americans.

THE ALAN GUTTMACHER INSTITUTE (AGI) is an independent, nonprofit corporation for research, policy analysis and public education in the fields of reproductive health, population and broadly related areas of health and social policy. AGI's nonpartisan programs and activities are aimed at promoting public understanding, developing sound public policy and creating workable public and private sector programs that will enhance the ability of all women and men, in freedom and dignity, to exercise their rights and responsibilities with regard to reproduction and family formation.

ALBUQUERQUE MONTHLY MEETING OF THE RELIGIOUS SOCIETY OF FRIENDS. In considering the morality of abortion, Quakers' respect for the sanctity of life may come in conflict with Quakers' respect for the individual leanings of the spirit. In other ethical dilemmas faced in history, some Quakers have found that traditional Friendly testimony may have conflicted both with the prevalent beliefs of the community at large and their own personal revelations. The Quaker approach of holding contradictory positions in the light of God, in silence, until the sense of the spirit is felt, is where we begin. Albuquerque Monthly Meeting feels that a woman, or a couple, facing these conflicts may reach clearness to terminate a pregnancy. Since we believe it is beyond the scope of government to make this moral decision for her, a woman should not be prevented by legislation from having reasonable access to a medically safe abortion. If a woman is eligible for financial assistance from a governmental agency for medical care, then such assistance should apply to an abortion just as it applies to any other medical procedure.

ALL PEOPLE'S CONGRESS,* based in New York City, is a national organization with chapters in communities in many major cities whose women members are Black, Latino, Asian and Native American, students, lesbians, workers, unemployed, disabled, seniors, single heads of households and those on fixed incomes. It strongly supports a comprehensive federal program of guaranteed reproductive rights and health care for all women, which includes safe, legal, affordable abortion.

THE AMERICAN FRIENDS SERVICE COMMITTEE (AFSC) has a vital interest in this litigation because of Friends belief in the infinite worth of each human being and the equality of all human beings in the sight of God. Because of this testimony, the AFSC has worked since 1917 as a social justice arm

of the Religious Society of Friends to root out the causes of violence in our society which lie in poverty, exclusion and denial of equal opportunity and rights and to support rights of conscience. For two decades the AFSC has taken a consistent position supporting a woman's right to follow her own conscience concerning childbearing, abortion and sterilization. AFSC is deeply aware that the decision to terminate pregnancy is seldom an easy one. That choice must be made free of coercion, including the coercion of poverty, racial discrimination and unavailability of services to those who cannot pay.

AMERICAN ASSOCIATION OF UNIVERSITY WOMEN (AAUW),* a network of 140,000 college-educated women, promotes equity for women and girls. The AAUW supports the right of every woman and girl to safe and comprehensive reproductive health care. AAUW believes that decisions concerning reproductive health care are personal ones, and that the right to make informed decisions should be available to *all* women.

AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES, AFL-CIO (AFSCME) is a union of over one million public employees, including over 300,000 health care workers. AFSCME also represents thousands of workers in social service agencies caring for abused, neglected and abandoned children. Over half of AFSCME's members are women.

AMERICAN HUMANIST ASSOCIATION (AHA) is a national philosophical and religious organization which has a strong interest in this litigation because its members hold the preciousness, dignity and freedom of conscience of the individual person as central values. The AHA has long held that freedom of conscience on abortions is a fundamental right of all women, and that any government action to limit that right is both an intolerable invasion of individual liberty and autonomy and an improper expansion of the power of the state.

THE AMERICAN JEWISH CONGRESS,* an organization of American Jews founded in 1918, is fully committed to protecting the right of all women to exercise reproductive choices. While it believes that involving parents in the choices of their

teenage daughters is desirable, it believes that such involvement cannot be mandated by law, because study after study demonstrates that these laws are wholly ineffective, even, in many cases, counterproductive.

THE AMERICAN JEWISH COMMITTEE (AJC)* is a national organization founded in 1906 for the purpose of protecting the civil and religious rights of Jews. The AJC believes that this goal can best be accomplished by helping to preserve the constitutional rights of all Americans. The AJC supports access to abortion on a voluntary basis as an important component of comprehensive and effective health care and as a part of its traditional concern for individual liberty, privacy, and free choice.

AMERICAN PUBLIC HEALTH ASSOCIATION (APHA)* is a national organization devoted to the promotion and protection of personal and environmental health and to the prevention of disease. Founded in 1872, APHA is now the largest public health organization in the world, with over 50,000 members, including fifty-one state and local affiliate organizations. The APHA represents all disciplines and specialties in public health, including both patients and health professionals such as physicians, nurses, health educators, and family planning specialists.

AMERICAN VETERANS COMMITTEE, INC. (AVC),* founded in 1943, is a national organization of veterans who served honorably in the Armed Forces of the United States in World War I, World War II, the Korean War, or the Vietnam War. AVC has filed *amicus* briefs in many court cases expressing AVC's strong belief that discrimination based on race, color, religion, sex, or national origin is detrimental to our Nation. AVC believes that the United States Constitution entitles a pregnant women, in light of her unique burden of pregnancy, to determine whether to terminate her pregnancy.

AMERICANS FOR DEMOCRATIC ACTION (ADA), a progressive, independent political organization, is a national coalition of civil rights and feminist leaders, academicians, business people and trade unionists, grass roots activists, elected offi-

cials, church leaders, professionals, members of Congress and many others. ADA is dedicated to the achievement of freedom, equality of opportunity, economic security and peace for all people through education and political action.

AMERICANS FOR RELIGIOUS LIBERTY is a nationwide non-denominational educational organization dedicated to defending the constitutional principles of religious freedom, freedom of conscience, and separation of church and state.

ASSOCIATION OF REPRODUCTIVE HEALTH PROFESSIONALS (ARHP) is a national nonprofit organization comprised of physicians, nurses, and other providers of reproductive health care services. ARHP's major purpose is to improve the quality of reproductive health care through professional and public education. The experience of ARHP and its members is that sound reproductive health care requires the ready availability to all women of childbearing age of a full range of modern medical services. These include, in addition to high quality obstetric care, contraceptives, genetic screening, counseling, and safe and legal abortion.

THE BEVERLY HILLS BAR ASSOCIATION (BHBA)** is a voluntary bar association formed on December 2, 1931 which currently has 3000 members. The members of BHBA practice in and around the City of Beverly Hills, California. BHBA is committed to the protection of individual liberties and to the promotion of respect for the legal system. BHBA believes that a reversal of the landmark decision in *Roe v. Wade* would impinge on individual liberties and would undermine public confidence in the legal system.

THE BLACK WOMEN'S AGENDA, INC. (BWA), in Washington, D.C., is a coalition of national Black women's organizations dedicated to equity and equality for Black women and their families. The BWA firmly believes that reproductive freedom is essential to our advancement.

** *Amicus* joins this brief on behalf of appellees in the case of *State of Ohio* v. *Akron Center for Reproductive Health* only. A double asterisk will so indicate throughout this Appendix.

B'NAI B'RITH WOMEN (BBW)*** is an organization of 120,000 Jewish women who, since 1968, have advocated the right of women to choose for themselves on matters of reproduction. As members of a minority religion, BBW members are especially sensitive to keeping the state from restricting religious freedom, and as women BBW members have particular concerns about preserving their rights. Basic to the right of every woman is that of deciding when and whether to have children, and so BBW firmly supports upholding these rights as outlined in *Roe* v. *Wade*.

BUFFALO LAWYERS FOR CHOICE is an organization currently of approximately fifty attorneys—men and women—formed in 1989 in Buffalo. All attorneys in the organization practice in Buffalo. Although they are from diverse backgrounds and practices, the group's members all have supported the right of women to choose abortion and have supported the equality between men and women. Buffalo Lawyers for Choice intends to continue as an active organization supporting local groups that protect individuals' ability to control their bodies and their lives. Many of the members have been active in the past in Planned Parenthood of Buffalo and Erie County and in national Planned Parenthood organizations, as well as civil liberties organizations. Because of an intense interest in the rights of women and men to make their own decisions about reproductive issues, Buffalo Lawyers for Choice wishes to be recognized as an *amicus* in these cases.

CALIFORNIA WOMEN LAWYERS (CWL)* is an organization of several thousand women lawyers founded in 1973 for the primary purpose of improving the situation of women in the State of California. CWL is committed to all issues affecting a woman's right to choice, lobbying against various parental consent bills and working with a broad-based coalition to encourage funding and support for programs supportive of choice.

*** *Amicus* has filed another *amicus* brief in the above-captioned cases, focusing on separate issues, but wishes to join this brief especially to support *Roe* v. *Wade*. A triple asterisk will so indicate throughout this Appendix.

CANADIAN ABORTION RIGHTS ACTION LEAGUE (CARAL). The main purpose of CARAL is to ensure that no woman in Canada is denied access to safe, legal abortion. Our aim is to keep abortion out of the *Criminal Code*. We want to see the establishment of comprehensive contraception and abortion services, including appropriate counseling across the country. We regard the right to safe, legal abortion as a fundamental right.

CATHOLICS FOR FREE CHOICE (CFFC)*** is an independent national membership organization established in 1974. One of CFFC's objectives is to protect the legal right of all women and girls to act as moral agents in decisions related to sexuality and reproductive health care without coercive legal or quasi-legal interference by religious institutions. As Catholics, CFFC members support policies of strict separation of church and state based not only on the United States Constitution, but also on the Roman Catholic Declaration on Religious Liberty (*Vatican II Dignitatis Humanae*, 7 December 1965) which declares, ". . . the civil authority must see to it that the equality of the citizens before the law, which is itself society, is never violated either openly or covertly for religious reasons and that there is no discrimination among its citizens."

CENTER FOR POPULATION OPTIONS (CPO)* is a national nonprofit organization dedicated to the prevention of unintended adolescent pregnancy and too-early childbearing. CPO develops programs to increase opportunities for young people through education, comprehensive health care, and the access to family planning services.

THE CENTER FOR WOMEN POLICY STUDIES (CWPS), founded in 1971, was the first national policy research and advocacy institute focused exclusively on issues of women's social and economic rights. The Center's current programs include the National Resource Center on Women and AIDS, the first national effort focused exclusively on women, particularly low income women and women of color; a key concern is the potential abrogation of women's reproductive rights in the name of protecting public health. CWPS also is conducting the

second stage—policy implementation and public education—of the Reproductive Laws for the 1990s Project. Finally, our Young Women's Project seeks to bring women in their twenties into the policy process and will address issues of reproductive choice from their perspectives.

THE CENTRE COUNTY WOMEN'S RESOURCE CENTER provides services to victims of sexual assault and domestic violence. It is the Center's firm philosophy and policy that, with the exception of mandated child abuse reporting, all people seeking services have the right to absolute privacy and confidentiality with respect to their personal lives, decisions, and bodily integrity. This philosophy and policy extends to people of all backgrounds, regardless of their age.

CHICAGO CATHOLIC WOMEN is an organization committed to working toward structural change within church and society in order to promote the full giftedness and personhood of women and a world of justice for all. We know that a woman's choice regarding her body must be respected. We have heard the pain of women who had illegal abortions before 1973 and we will work to keep a woman's choice legal.

CHILD CARE LAW CENTER,* in San Francisco, California, is the only legal services organization in the country exclusively dedicated to expanding the supply of affordable, quality child care. It has a particular emphasis on serving the needs of low-income women, and as such it strongly supports the rights of low-income women to have equal access to health services, including abortion.

CHOICE (CONCERN FOR HEALTH OPTIONS: INFORMATION, CARE AND EDUCATION). For almost twenty years, CHOICE has been an educator, consumer advocate, counselor and information resource in the areas of reproductive health, sexuality and maternity care. Because of its background and experience in public education and counseling, CHOICE was selected by the City of Philadelphia to operate its city-wide hotline for information on AIDS. CHOICE, through its information hotlines, teen improvisational theater company, training center and publications, has pursued an organizational

philosophy that decisions regarding sexuality and reproduction are highly personal, and that those very private choices should not be constrained by private or public intimidation, economic or social status, lack of relevant information or unwarranted governmental interference.

CHOICE ATTORNEYS NETWORK, subscribes to the general statement of interest of *amici*, *supra*, at p. 2.

CHOICE, INC., subscribes to the general statement of interest of *amici*, *supra*, at p. 2.

CHOICES WOMEN'S MEDICAL CENTER* is a New York State licensed medical facility serving over 30,000 patients a year in the New York City area for family planning, abortion, and prenatal care. Since its founding in 1971, Choices Women's Medical Center has been at the forefront of insuring high quality feminist women's health care for its patients and fighting politically to retain the right to choose.

THE COALITION OF LABOR UNION WOMEN (CLUW) is a national membership organization of women and men who are members of more than sixty-five International Unions. CLUW has forty-five active chapters throughout the United States and a National Executive Board composed of the female leadership of these International Unions. A primary purpose of this national coalition is to unify all Union Women in a viable organization dedicated to the achievement of participation of women within their unions and to remove all forms of discrimination from the workplace.

COLORADO WOMEN'S BAR ASSOCIATION is a nonprofit professional association of more than 600 Colorado lawyers and law students. Open to all attorneys regardless of sex, the CWBA was founded in 1977 to promote the highest standards of the legal profession; to advance justice; to promote, advance, and protect the interests and welfare of women; and to pursue these goals through appropriate legal, social, and political action. The CWBA supports reproductive freedom, and opposes any infringement on a woman's constitutional right of privacy to make her own reproductive choices.

THE COLUMBIA-GREENE RAPE CRISIS CENTER, based in New York, was founded in 1981. It assists approximately 400 women per year who have been the victims of sexual assault, their families and friends, to overcome the trauma of sexual assault. It also serves 7000 community residents per year through its sexual abuse prevention project. Pregnancy can result from any number of situations, many of which do *not* include "irresponsibility" on the part of the woman. The Rape Crisis Center sees many unwanted pregnancies resulting from sexual crimes and supports a woman's freedom of choice over her personal medical and emotional concerns, including the right to terminate an unwanted pregnancy.

THE COMMITTEE OF INTERNS AND RESIDENTS (CIR)* is the nation's oldest and largest housestaff union, representing over 5000 interns, residents and fellows in New York, New Jersey, and Washington, D.C. For over thirty years, the CIR's struggle to improve residents' working conditions has been inseparable from its fight for quality patient care. The CIR strongly supports the right of all women to safe, legal birth control and abortion.

THE COMMITTEE TO DEFEND REPRODUCTIVE RIGHTS (CDRR-CMRW), founded in 1977, is a San Francisco-based grass roots organization with a nationwide membership of almost 2000 people. CDRR-MRW and its membership advocate the right to legal, affordable, and safe abortion services for all women, regardless of their age, race, income level, or sexual preference. CDRR-CMRW considers abortion a vitally important and needed health service and a constitutionally-protected right for all women.

CONNECTICUT WOMEN'S EDUCATION AND LEGAL FUND, INC.,* with over 400 members, is a nonprofit public interest law firm advocating women's rights. As an organization working for equality, we believe that every woman, without regard to age, religious belief, income, race or disability, must be able to control her own health and reproduction.

THE D.C. RAPE CRISIS CENTER was established in 1972 to provide services to sexual assault survivors. The Center is inter-

ested in these cases because we maintain a strong concern for issues that affect women, particularly low-income and women of color. We believe that issues of economics, health, justice, education, etc. are all intertwined. Though our primary focus is violence against women, we consistently support actions that promote justice for women, which includes the right to reproductive freedom.

THE D.K.T. MEMORIAL FUND is a private organization based in Washington, D.C. which supports and supervises family planning projects, primarily in developing countries, including the provision of birth control options for men. The DKT Memorial Fund is dedicated to the furtherance of a woman's right to reproductive freedom, including the right to choose abortion.

DOMESTIC VIOLENCE CENTER OF CHESTER COUNTY is an organization which provides a hotline, safe housing, and comprehensive counseling to battered women. The Center served 743 women and 144 children between July 1987 and June 1988. A great many of the women served are single parents with low incomes. These women must struggle to procure fair access to health care services. We strongly oppose inequitable treatment for low-income women denied fair access to medical services including abortion.

EPISCOPAL WOMEN'S CAUCUS* is deeply disturbed over the increasingly bitter and divisive battle being waged in legislative bodies to force continuance of unwanted pregnancies and to limit an American woman's right to abortion. We believe that all should be free to exercise their own consciences on this matter and that where widely differing views are held by substantial sections of the American religious community, the particular belief of one religious body should not be forced on those who believe otherwise. To prohibit or severely limit the use of public funds to pay for abortions abridges and denies the right to an abortion and discriminates especially against low income, young, and minority women.

EQUAL RIGHTS ADVOCATES, INC. (ERA) is a San Francisco-based public interest legal and educational corporation founded in 1974 that is dedicated to securing economic, social, and political equality for women. It has a long history of interest, activism, and advocacy in all areas of law which affect equality between the sexes. ERA believes that the right to control one's reproductive life is fundamental to women's ability to gain equality in other aspects of society. This concern has been expressed through our participation as counsel and as *amicus* in numerous cases involving women's reproductive rights, including *Committee to Defend Reproductive Rights v. Meyers*, 29 Cal.3d 252 (1981) and related cases.

THE FEDERATION OF FEMINIST WOMEN'S HEALTH CENTERS is a nonprofit association of women's health projects and supporters. The network of women-controlled health clinics share staff, training and resources to advocate, promote and protect reproductive rights for all women. Approximately 15,000 women, at least ten to twenty percent of whom are minors, receive abortion services at our health clinics yearly. The Federation's goal is to enable women to make informed choices about their health care and reproduction through the provision of self-help health education and gynecological services, including abortion, well-women care and birth-control. We work together and with others to ensure that all women have the information and power to control their bodies and their lives.

FEDERATION OF RECONSTRUCTIONIST CONGREGATIONS AND HAVUROT.* Although the Jewish tradition regards children as a blessing, the tradition permits the abortion of an unborn child to safeguard the life and physical and mental health of the mother. The rabbis did not take a consistent stand on the question of whether a fetus resembles "a person." They did not think it possible to arrive at a final theoretical answer to the question of abortion, for that would mean nothing less than to be able to define convincingly what it means to be human. We recognize that abortion is a tragic choice. Any prospective parent must make an agonizing decision between competing claims—the fetus, health, the need to support oneself and one's family, the need for time for a marriage to stabilize, responsibility for other children and the like. Some of us consider abor-

tion to be immoral except under the most extraordinary circumstances. Yet we sympathize with the anguish of those who must make the decision to abort or not to abort.

THE FEMINIST INSTITUTE promotes social change that ensures women's autonomy and independence. Our women's health policy and pro-choice projects promote public policies that ensure women's control over their own bodies. We are concerned that, as women become free from subjugation to patriarchal control within the family, they in turn not become subject to state control of their reproduction. Control over one's own body is fundamental to the exercise of personal autonomy, without intervention or restriction by the government.

FLORIDA ASSOCIATION FOR WOMEN LAWYERS, DADE CHAPTER, was founded in 1979 and is comprised of over 600 members. The Association is dedicated to the preservation of women's rights, including the right to make decisions about whether and when to have children.

FOSSIL FUELS POLICY ACTION (FFPA) is concerned about the effects of present fossil fuels production and consumption, primarily that of pollution, and secondarily, but importantly, the worsening of energy security. FFPA supports advancing and safeguarding the right—and what should be the requirement—to provide information on population and environment to all consumers, notably expectant mothers and teenagers, in the context of added consumers' impact on—and unhealthy future in—our fossil fuels intensive society and economy. Restricting abortions in early pregnancy aggravates population pressures on the environment and on finite resources. This does not mean abortion should be a preferred means of birth control or of limiting population.

FRESNO FREE COLLEGE FOUNDATION* is a community organization with offices in Fresno, California. Its origin in 1968 is connected to an academic freedom case and, since that time, it has, in various ways, been supportive of academic freedom and the civil liberties of students, professors, and citizens.

FUND FOR THE FEMINIST MAJORITY is a nonprofit organization with supporters nationwide and offices in Arlington, Virginia, and Los Angeles, California, dedicated to eliminating sex discrimination and to the promotion of equality, women's rights, and a feminist agenda including legal, safe and accessible abortion and birth control. The Fund is also a producer of educational materials to enhance public understanding of the need for legal abortion to further public health.

THE GAY MEN'S HEALTH CRISIS, INC. (GMHC), based in New York City, is the nation's oldest and largest community-based AIDS service, education and advocacy organization. As of January 1989, approximately four percent of GMHC's 2,471 active clients were women. The majority of our female clients are women of color. GMHC is concerned that our female clients and women in general affected by the HIV epidemic be able to make their own medical decisions and that one option that must be available is a safe and legal abortion regardless of a woman's financial status.

HADASSAH is a women's Zionist organization representing over 385,000 members. It supports the principle of individual freedom as guaranteed by the Constitution, and opposes any regulations that diminish that freedom. In this respect, Hadassah regards freedom of choice as a matter of privacy of the individual to be determined by each woman in accordance with her religious, moral, and ethical values.

HARVARD WOMEN'S LAW ASSOCIATION BOARD was founded in 1969. It is currently celebrating its twentieth year at Harvard Law School, where women have been students for thirty-eight years. Most of the almost 700 women currently attending Harvard Law School attend some Women's Law Association events; many participate in the Battered Women's Project which the Women's Law Association co-sponsors. Over 200 women, almost one-third of the women at Harvard Law School, are paying, voting members of the Women's Law Association. Among the Women's Law Association's objectives are informing the law school and the broader community about

issues of concern to all women at Harvard Law School and promoting women's rights, such as the right to choose an abortion.

HAWAII WOMEN LAWYERS* is dedicated to the improvement of the status of women attorneys and the support of issues of concern to all women, so as to promote the advancement of all women.

THE HAWAII WOMEN LAWYERS FOUNDATION is a professional organization of women and men attorneys and others. One of its main purposes is to advance the status of women in the community. Members have been involved in many projects which aid women lawyers and women in the community in general. Foundation members are aware that women's right to choose abortion is constitutionally protected. Women must have the right to reproductive freedom if they are to have physical control over their own bodies. Without reproductive autonomy, women can neither control the course of their lives nor participate equally in society. The Hawaii Women Lawyers Foundation supports reproductive freedom for women and opposes any and all efforts to limit women's right to choose abortion.

THE HUMAN RIGHTS CAMPAIGN FUND is a lobbying organization representing the national gay and lesbian community. Since its founding nearly ten years ago, the Campaign Fund has been committed to working toward full civil rights for lesbians and gay men and ultimately for all Americans. In pursuit of this goal, we are interested in any governmental actions—legislative, judicial, or administrative—that could affect civil rights.

ILLINOIS WOMEN'S AGENDA (IWA), founded in 1975, is a statewide coalition of organizations and individuals committed to full equality and justice for women. Current IWA membership consists of several hundred individual members and over fifty affiliated organizations, representing 80,000 women throughout Illinois in the fields of law, academia, labor, and business, among others. The IWA develops and participates in

a wide range of programs for women through research, public education, and advocacy.

THE INTERNATIONAL AGENCY FOR MINORITY ARTISTS AFFAIRS (IAMAA) is a nationwide membership organization based in New York City which serves as an arts, cultural and social services agency. One of our primary concerns is the promotion of women's rights. Our founder is Queen Mother Moore, who is now ninety-one years of age, and Ms. Flo Kennedy, attorney and feminist leader. The Executive Board of the IAMAA fully supports the freedom of choice of women pertinent to abortion and stands firmly against any modification of the *Roe* decision.

INTERNATIONAL FUND FOR HEALTH AND FAMILY PLANNING (IFHFP) is a private foundation based in Washington, D.C., which supports and supervises family planning projects, primarily in developing countries. These programs include the provision of a wide variety of contraceptive and birth control options for women and men around the world. The IFHFP is dedicated to the furtherance of women's rights to reproductive freedom, including the right to choose abortion.

INTERNATIONAL LADIES' GARMENT WORKERS UNION (ILGWU) is an international labor organization of approximately 175,000 members located in thirty-three states of the United States. More than eighty-five percent of its members are women, many of whom are minorities, and a substantial majority of whom are of child-bearing age. Many of the women members live at a low income level. ILGWU is dedicated, among other principles, to the elimination of gender discrimination, the promotion of women in the workplace, and the constitutional guarantees declared in *Roe v. Wade*.

INTERNATIONAL PROJECT ASSISTANCE SERVICES (IPAS) is a non-governmental, charitable organization based in Carrboro, North Carolina, that works around the world, and especially in developing countries, toward safe reproductive health care for women. It provides training, information, and other educational services regarding access to and delivery of comprehensive health services, especially abortion. In countries

where abortion is restricted, IPAS works within prevailing cultural, legal and social contexts to reduce the maternal morbidity and mortality associated with unsafe abortion practices. In countries where abortion services are not so restricted, IPAS works to improve access to safe abortion services.

INSTITUTE FOR COMMUNITY RESEARCH has as its mission the improvement of the quality and availability of critical information to underserved people in the Hartford, Connecticut capital area and beyond. The Institute supports the right of poor women and women of color to information about abortion and other reproductive health issues, and to the constitutional right to reproductive health self-determination, including the right to abortion and abortion counseling, and appropriate financing to support these choices.

THE INSTITUTE FOR WOMEN'S POLICY RESEARCH (IWPR) is an independent, nonprofit, scientific research institution established to respond to the need for women-centered, policy-oriented research. IWPR conducts research that addresses the full spectrum of issues that impact on women's lives—with sensitivity to and consideration for diversity based on race, ethnicity, and class. The focus of the Institute's research is both national and international in scope. In all aspects of its endeavors, IWPR is committed to expanding access, strengthening relationships, and fostering partnerships which strengthen the economic, social, and political well-being of all women. IWPR gives its full support to the *amicus curiae* brief in these cases. IWPR urges the Court to uphold women's right to reproductive choice because, among other reasons, women's right to reproductive choice is a key element in their ability to achieve economic equity.

INSTITUTE FOR WOMEN TODAY, subscribes to the general statement of interest of *amici*, *supra*, at p. 2.

THE JESSIE SMITH NOYES FOUNDATION is a private foundation committed to preventing irreversible damage to the natural systems upon which all life depends. The Foundation makes grants in the closely interrelated areas of environment and population. The Foundation, therefore, believes that

reproductive rights are essential to achieving a balance between environment and population as well as for the individual dignity of women.

JEWISH COMMUNITY AGENCIES. Having long sought to insure the protections afforded by the Constitution and the Bill of Rights, the following Jewish community agencies join this *amicus* brief. The Jewish community shares with others the reverence for life on the one hand, and the pluralistic society's concern for individual rights and religious liberty on the other. Within the Jewish community itself, there is a spectrum of positions on the matter of abortion. For this reason, we believe that the Supreme Court should retain the rules set forth in *Roe* v. *Wade* so that the abortion decision can be made by individual women in accordance with their own religious and moral views, consulting with their physician and spiritual advisors.

AKRON JEWISH COMMUNITY FEDERATION
ALBUQUERQUE JEWISH COMMUNITY COUNCIL
ATLANTIC COUNTY FEDERATION OF JEWISH AGENCIES
AUSTIN JEWISH COMMUNITY COUNCIL
BINGHAMTON JEWISH FEDERATION OF BROOME COUNTY
CANTON JEWISH COMMUNITY FEDERATION
CENTRAL NEW JERSEY JEWISH FEDERATION
CHARLESTON JEWISH COMMUNITY COUNCIL
CINCINNATI JEWISH COMMUNITY FEDERATION
CLIFTON-PASSAIC JEWISH FEDERATION
COLUMBIA COMMUNITY RELATIONS COUNCIL OF JEWISH WELFARE FEDERATION
COLUMBUS COMMUNITY RELATIONS COMMITTEE OF JEWISH FEDERATION
COMMUNITY RELATIONS COUNCIL OF JEWISH FEDERATIONS OF PALM BEACH COUNTY
DELAWARE VALLEY JEWISH FEDERATION
EASTERN CONNECTICUT JEWISH FEDERATION
ELMIRA COMMUNITY RELATIONS COMMITTEE OF JEWISH WELFARE FUND

EL PASO JEWISH COMMUNITY RELATIONS COMMITTEE
ERIE JEWISH COMMUNITY COUNCIL
FLINT JEWISH FEDERATION
FORT WORTH JEWISH FEDERATION
GREATER BOSTON JEWISH COMMUNITY RELATIONS COUNCIL
GREATER BRIDGEPORT JEWISH FEDERATION
GREATER BUFFALO JEWISH FEDERATION
GREATER DALLAS JEWISH COMMUNITY RELATIONS COUNCIL OF JEWISH FEDERATION
GREATER DANBURY COMMUNITY RELATIONS COMMITTEE OF JEWISH FEDERATION
GREATER DAYTON COMMUNITY RELATIONS COUNCIL OF JEWISH FEDERATION
GREATER DES MOINES JEWISH FEDERATION
GREATER FORT LAUDERDALE JEWISH FEDERATION
GREATER HARTFORD COMMUNITY RELATIONS COMMITTEE OF JEWISH FEDERATION
GREATER KANSAS CITY JEWISH COMMUNITY RELATIONS BUREAU
GREATER KINGSTON JEWISH FEDERATION
GREATER MIAMI JEWISH FEDERATION
GREATER MIDDLESEX COUNTY JEWISH FEDERATION
GREATER NEW ORLEANS JEWISH FEDERATION
GREATER NORWALK JEWISH FEDERATION
GREATER ORANGE COUNTY JEWISH FEDERATION
GREATER ORLANDO JEWISH FEDERATION
GREATER PHILADELPHIA JEWISH COMMUNITY RELATIONS COUNCIL
GREATER SAN JOSE JEWISH COMMUNITY RELATIONS COUNCIL
GREATER SEATTLE JEWISH FEDERATION
GREATER WASHINGTON JEWISH COMMUNITY COUNCIL
GREATER WILKES-BARRE JEWISH FEDERATION
INDIANAPOLIS JEWISH COMMUNITY RELATIONS COUNCIL

JACKSONVILLE JEWISH FEDERATION
JEWISH COMMUNITY RELATIONS COUNCIL OF INDIANA
LEXINGTON CENTRAL KENTUCKY JEWISH FEDERATION
LOS ANGELES COMMUNITY RELATIONS COMMITTEE OF JEWISH FEDERATION COUNCIL
LOUISVILLE JEWISH COMMUNITY
MADISON JEWISH COMMUNITY COUNCIL
MARBLEHEAD NORTH SHORE JEWISH FEDERATION
MEMPHIS JEWISH COMMUNITY COUNCIL RELATIONS COUNCIL
METROPOLITAN DETROIT JEWISH COMMUNITY COUNCIL
METRO WEST UNITED JEWISH FEDERATION
MILWAUKEE JEWISH COUNCIL
NEW HAVEN JEWISH FEDERATION
NORTHEASTERN NEW YORK UNITED JEWISH FEDERATION
NORTHERN NEW JERSEY JEWISH COMMUNITY RELATIONS COUNCIL
OKLAHOMA CITY JEWISH COMMUNITY COUNCIL
PEORIA JEWISH FEDERATION
PITTSBURGH COMMUNITY RELATIONS COMMITTEE OF UNITED JEWISH FEDERATION
PORTLAND JEWISH FEDERATION
PORTLAND SOUTHERN MAINE JEWISH FEDERATION-COMMUNITY COUNCIL
PROVIDENCE COMMUNITY RELATIONS COMMITTEE OF RHODE ISLAND JEWISH FEDERATION
RICHMOND JEWISH COMMUNITY FEDERATION
ROCHESTER JEWISH COMMUNITY FEDERATION
SACRAMENTO JEWISH COMMUNITY RELATIONS COUNCIL
SAN ANTONIO JEWISH COMMUNITY RELATIONS COUNCIL OF JEWISH FEDERATION
SAN FRANCISCO JEWISH COMMUNITY RELATIONS COUNCIL
SAVANNAH JEWISH COUNCIL

SCRANTON-LACKAWANNA JEWISH FEDERATION
SOUTH BEND JEWISH FEDERATION OF ST. JOSEPH VALLEY
SOUTH BROWARD JEWISH FEDERATION
SOUTH COUNTY JEWISH FEDERATION
SOUTHERN NEW JERSEY JEWISH COMMUNITY RELATIONS COUNCIL
SPRINGFIELD (ILLINOIS) JEWISH FEDERATION
SPRINGFIELD (MASSACHUSETTS) JEWISH FEDERATION
STAMFORD UNITED JEWISH FEDERATION
SYRACUSE JEWISH FEDERATION
TIDEWATER UNITED JEWISH FEDERATION
TULSA JEWISH COMMUNITY COUNCIL
UTICA JEWISH FEDERATION
WATERBURY JEWISH FEDERATION
WILMINGTON JEWISH FEDERATION OF DELAWARE
WORCESTER JEWISH FEDERATION
YOUNGSTOWN JEWISH COMMUNITY RELATIONS COUNCIL OF JEWISH FEDERATION

JEWISH LABOR COMMITTEE objects to any governmental attempts to interfere in the exercise of individual religious conscience with regard to procreative choice. Because we recognize the many divergent theological answers to the questions raised by abortion, we agree that each woman should be free to consult with her religious convictions, as well as her best medical advice, without government coercion or constraint when exercising religious and personal conscience in making a decision whether to terminate her pregnancy.

THE JUDICIAL CONSENT FOR MINORS LAWYER REFERRAL PANEL* is a volunteer association of over 200 Massachusetts lawyers who for the last eight years have represented more than 6000 pregnant minors seeking judicial consent for an abortion (in lieu of parental consent) under Mass. Gen. Laws ch. 112,/12S.

THE JUVENILE LAW CENTER (JLC)* is a public interest law firm that has provided free legal services to children in

Pennsylvania since 1975, represented hundreds of abused and neglected children in Philadelphia Family Court, and been involved in numerous federal and state cases aimed at vindicating the rights of children who are served by the government. Many JLC clients have been teenage parents. Based upon its experience and expertise with teenage girls, JLC wishes to bring to the Court's attention facts concerning the medical risks and societal cost of teenage pregnancy and childbearing, and to urge that the Court uphold the fundamental right to choose abortion recognized in *Roe v. Wade*.

LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.,* founded in 1973, is the nation's oldest and largest national legal advocacy organization working in furtherance of the rights of lesbians and gay men. As an organization representing the lesbian and gay community's belief in the constitutional right to liberty and bodily autonomy, Lambda strongly supports the position that women in our society are constitutionally entitled to make their own decisions about whether to choose abortion.

LAWYERS CLUB OF SAN DIEGO, INC.* is a California bar association founded in 1972 with a current membership of almost 700 men and women, most of whom practice and reside in San Diego County, California. The purpose of the Lawyers Club is "to advance the status of women in the law, to support and improve the administration of justice and to promote equality of the sexes in our society." The rights of liberty and privacy are key to equality of the sexes. Lawyers Club believes that any encroachment on the protections afforded by the Constitution and *Roe v. Wade* would destroy the fundamental rights of women to control their pregnancies and their bodies.

LAWYERS FOR REPRODUCTIVE RIGHTS (LRR) is a nonprofit organization located in Philadelphia, Pennsylvania which represents more than 700 members of the five-county legal community and is actively helping to organize affiliate groups across Pennsylvania and in New York City. LRR believes that lawyers have a special and significant role to play in opposing governmental interference in the private lives of

individuals and in educating the legal community and the general public about legal issues of reproductive rights.

LEAGUE OF WOMEN VOTERS OF THE UNITED STATES (LWVUS)* is a nonpartisan, nonprofit membership organization with members in state and local Leagues in all fifty states, the District of Columbia, Puerto Rico, and the Virgin Islands. The LWVUS strongly believes that public policy in a pluralistic society must affirm the constitutional right of privacy of the individual to make reproductive choices. The LWVUS further believes that the *Roe v. Wade* decision is an important protection of this constitutional right.

MARIE STOPES INTERNATIONAL, founded in 1973, is the largest non-governmental provider of family planning services in Britain, and supports full-service birth control programs in fifteen other countries, including India, Sri Lanka, Indonesia, the Philippines, Bangladesh and Kenya. In all countries in which it works, the organization is deeply concerned with the administrative, legislative and judicial issues that restrict the fundamental human right of the individual to all forms of birth control.

THE METRO D.C. COALITION FOR CHOICE in Washington, D.C., has as its purpose the mobilization of local support for the reproductive rights of all women and to represent the unique needs of the residents of the District of Columbia in the area of reproductive rights. Women of color make up a large percentage of the D.C. population, so we feel it is important to endorse this brief.

THE MEXICAN AMERICAN LEGAL DEFENSE AND EDUCATION FUND (MALDEF) is a national civil rights organization based in Los Angeles and established in 1967. Its principal objective is to secure, through litigation and education, the civil rights of Hispanics living in the United States. In this context, MALDEF has advocated on behalf of Hispanic women for equality of access to health services and facilities. Any restriction on a woman's right to choose an abortion will have a disproportionate impact on the Hispanic community's

self-determination and ability to obtain equality of opportunity.

MICHIGAN REPUBLICANS FOR CHOICE PAC in Grand Rapids, Michigan is a statewide organization of approximately 1000 men and women. They support the right of a woman to decide when to bear children and when not to bear children. They believe in the right to privacy and believe that right is supported in the Constitution.

MISSOURI WOMEN'S NETWORK* is a banding together of Missouri organizations and individual women and men to facilitate communication, promote education, and to strengthen advocacy for women's issues based on the 1977 National Plan of Action for Women (adopted in Houston).

MOBILIZATION FOR YOUTH HEALTH SERVICES, INC.* is concerned that the erosion of *Roe v. Wade* will lead us back to the days where social class and ability-to-pay were highly determinative of whether choice was available and, if available, whether that choice was exercised under conditions of hygiene, care, and skill normally accepted as standard for the medical profession. Social realities being what they are, the victims of the curtailment of an essential right for women would be millions of disadvantaged and poor women in the United States.

THE MS. FOUNDATION FOR WOMEN is the nation's only public, multi-issue, women's fund. The Foundation has long recognized that the extent to which women can control their reproductive capacities is a principal factor in determining the quality and character of their lives; this is especially true for poor women and women of color, who are often the first victims of anti-choice legislation. The Ms. Foundation for Women has been responding to attacks on reproductive freedom with a combination of grantmaking, technical assistance, and advocacy since its founding almost fifteen years ago.

NA'AMAT. Reproductive choice must be recognized as a matter of individual conscience outside the realm of government intrusion. We oppose attempts—whether by Constitutional

amendment, legislation, judicial review, or governmental regulation—to restrict women's access to safe and legal abortion or to violate the confidentiality of family planning services.

THE NATION INSTITUTE, of New York City is a nonprofit foundation founded in 1966 which undertakes research, educational programs and other projects concerned with civil rights and civil liberties, particularly those protected by the First Amendment. The Supreme Court Watch project of The Nation Institute is an example of our commitment to these isssues.

NATIONAL ABORTION FEDERATION** is a professional membership organization of abortion providers representing 300 clinics, doctors' offices, and hospitals throughout the United States and Canada.

THE NATIONAL ABORTION RIGHTS ACTION LEAGUE (NARAL) has 350,000 members in thirty-seven state affiliates and the national organization. Founded in 1969, NARAL is the largest national organization dedicated solely to keeping abortion safe, legal, and accessible. NARAL recognizes that guaranteeing women the full range of reproductive choices is critical to women's autonomy and equality.

NATIONAL ASSEMBLY OF RELIGIOUS WOMEN (NARW)* is a twenty-year old national organization of Catholic feminist women committed to working and acting collectively to build a world of peace with justice. NARW's agenda emphasizes the "participation of people in the decisions which affect their lives" and calls upon its members to use their organized power to effect a just society. NARW affirms the equal access of all women to the law, and opposes efforts to make abortion a crime. NARW believes that its position is based on gospel values of respect for life, respect for persons' self determination, fidelity to conscience, and the right to due process of law.

THE NATIONAL ASSOCIATION OF NURSE PRACTITIONERS IN REPRODUCTIVE HEALTH (NANPRH) was founded in 1980 for the purpose of assuring accessible quality family planning services which guarantee reproductive freedom

to all women, and to promote and protect the delivery of family planning services by nurse practitioners. NANPRH's 800 members believe that the abortion decision is one that must be made by the woman and her health practitioner.

THE NATIONAL ASSOCIATION OF SOCIAL WORKERS, INC. (NASW),* a nonprofit professional association with over 120,000 members, is the largest association of social workers in the United States. Founded in 1955, NASW has chapters in every state as well as the Virgin Islands, Puerto Rico, and Europe. NASW is devoted to promoting the quality and effectiveness of social work practice, to advancing the knowledge base of the social work profession and to improving the quality of life through the utilization of social work knowledge and skill. NASW is deeply committed to the principle of self-determination and to the protection of individual rights and personal privacy. The Association has been in the forefront of the struggle for women's equality, and is particularly concerned in the present instance that the state not override a pregnant women's autonomy nor restrict her right to choose abortion.

NATIONAL ASSOCIATION OF WOMEN LAWYERS (NAWL), founded in 1899, is a voluntary national membership organization of the legal profession, having official representation in various organizations, commissions and governmental agencies, both national and international. It is comprised of approximately 1200 individual members and numerous women's bar association affiliate members (encompassing several thousand additional members) across the country. Its individual members, from each state and the District of Columbia, include prosecutors, public defenders, private attorneys, trial and appellate judges from the state and federal courts, legislators, law professors, and law students. Although the members of the NAWL hold a broad spectrum of views, they share a common concern that the law be administered justly, fairly, and predictably. As an organization made up primarily of women, it has and continues to be a supporter of women's rights. As an organization of attorneys, it supports the integrity of the justice system.

NATIONAL BLACK WOMEN'S HEALTH PROJECT (NBWHP). Based in Atlanta, Georgia, the project was founded as a self-help and health advocacy organization to improve the chronically poor and declining health status of Black women and their families. Today it consists of a network of eighty-eight developing and established chapters in twenty-four states, serving a broad based constituency of almost 2000 members. The purpose of NBWHP is the definition, promotion, and maintenance of health for Black women, including full reproductive rights, the essential authority of every woman to choose when, whether, and under what conditions she will bear children. Because too many single family households in the United States are headed by Black women living in poverty, possessing less educational and job training opportunities, enduring inadequate, often nonexistent child care services, subject to substandard housing conditions, and lacking access to appropriate health services of any kind; wherefrom, more than half of all Black children are poor, born of mothers receiving inferior, if any, prenatal care, suffering the highest rate of infant mortality and neonatal deaths in the Western world; and because we lack fail-safe birth control methods, adequate human sexuality education, and suffer also the highest rate of teenage pregnancy in the Western world, we firmly insist upon continued access to safe, legal and affordable abortion. Restrictive abortion laws exacerbate the low socioeconomic status of women of color and passage of such laws will further impugn the dignity of Black womanhood, leaving sterilization as the only publicly funded and permanent birth control method available to women of color. The lives of Black and other women of color will be disproportionately damaged as we are forced to rely on publicly funded health facilities where they exist.

NATIONAL COALITION OF AMERICAN NUNS, subscribes to the general statement of interest of *amici*, *supra*, at p. 2.

NATIONAL COALITION OF 100 BLACK WOMEN* is a nonprofit consortium of professional African American women with a shared goal of improving the quality of life for black women and their families. The coalition endorses this

brief because, regardless of our individual views on abortion, we must have the right to choose and we must have that right protected.

NATIONAL CONFERENCE OF WOMEN'S BAR ASSOCIATIONS (NCWBA) is a nonprofit professional organization of 50,000 female and male attorneys. Membership is open to all individual state, regional, and local bar associations. The NCWBA was formed in 1981 to promote the highest standards of the legal profession, to advance justice, to promote and protect the interests of women, and to pursue these goals through appropriate legal, social and political action.

NATIONAL COUNCIL FOR RESEARCH ON WOMEN* is an independent association of established centers and organizations that provide institutional resources for feminist research, policy analysis, and educational programs for women and girls. The Council also works to strengthen ties with other national and international organizations and coalitions. Through its member centers and affiliates, the Council links over 2000 women and men scholars and practitioners in this country and abroad and serves constituencies that include government, the media, business and industry, and the nonprofit sector, as well as the academic community and the general public.

NATIONAL COUNCIL OF JEWISH WOMEN,* founded in 1893 and numbering 100,000 members across the United States, is dedicated, in the spirit of Judaism, to advancing human welfare and the democratic way of life through a combination of social action, education and community service. It has adopted a National Resolution to work for the "protection of every female's right to choose abortion, and the elimination of obstacles that limit reproductive freedom."

NATIONAL COUNCIL OF NEGRO WOMEN (NCNW) is an umbrella organization of national organizations. It was founded in 1953 by Mary Bethune. From its inception NCNW has sought to harness the collective strengths of Black women in the struggle for civil and human rights. It has half a century of civil rights leadership and public service on behalf of women and their families in the U.S. and developing African countries.

Teenage pregnancy is one of many of the current program emphases. NCNW embraces thirty-three national organizations and 254 chartered community based sections with an outreach to four million women in all walks of life whose mission is inspired by Mary Bethune to 'Leave No One Behind.'

NATIONAL EDUCATION ASSOCIATION (NEA) is a nationwide employee organization with a current membership of some 1.9 million members, the vast majority of whom are employed by public education institutions. One of the principle purposes of NEA is to protect the constitutional rights of its members, approximately 60% of whom are female. By action of its Representative Assembly, which is NEA's highest governing body, NEA expressly supports the right to reproductive freedom, which is implicated in this case.

NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION (NFPRHA)* is a nonprofit membership corporation designed to improve and expand the delivery of comprehensive family planning and reproductive health care information and services throughout the United States. NFPRHA represents over eighty-five percent of the agencies and organizations that operate family planning programs with funds received under Title X of the Public Health Services Act of 1970.

NATIONAL FEDERATION OF BUSINESS AND PROFESSIONAL WOMEN'S CLUBS, INC. (BPW/USA) is the world's oldest and largest organization of working women. Founded in 1919, and with 125,000 members in 3,400 local organizations across the country, BPW/USA promotes full participation, equity, and economic self-sufficiency for working women. BPW/USA includes among its members men and women of every age, religion, race, political party, and socioeconomic background. BPW's platform commits us to "support reproductive freedom as a right for all women."

NATIONAL FEDERATION OF TEMPLE SISTERHOODS represents the women of Reform Judaism. It is the women's affiliate of the Union of American Hebrew Congregations, and comprises more than 100,000 members among its affiliate sis-

terhoods. We believe that the right of choice is a personal one based on religious, ethical, or cultural beliefs and values. This right should not be determined for women based on the convictions of any special interest group. For government to legislate in the matter of abortion violates a woman's fundamental right to privacy and choice, and is an impermissible derogation of the separation of church and state. We therefore reaffirm our support of the Supreme Court decision of 1973 relating to abortion.

NATIONAL GAY AND LESBIAN TASK FORCE (NGLTF)* is a national membership advocacy and political organization to protect and advance civil and social rights of lesbians and gay men. Founded in 1973, NGLTF has 15,000 members, and offices in Washington, D.C. NGLTF strongly supports the reproductive freedom of all women and the expansion of fundamental right to privacy of all people in the area of reproductive and sexual decision making. Bodily integrity is an essential aspect of reproductive decisions and sexual privacy.

NATIONAL GAY RIGHTS ADVOCATES (NGRA)* is a nonprofit public interest law firm founded in 1978. NGRA engages in impact litigation throughout the country on behalf of lesbians and gay men. Today, NGRA has over 20,000 members from every state and the District of Columbia. Preserving the constitutional rights to liberty and privacy, rights that are principle components of a woman's right to choose abortion, are of fundamental concern to NGRA's work and its membership. If these essential rights are eroded, lesbians and gay men will also be denied equal participation in American society.

NATIONAL MEDICAL ASSOCIATION (NMA). Founded in 1895, the NMA is the oldest black organization in the United States and has a membership of over 16,000 black and minority physicians representing all states in the union. As stated in the NMA's constitution, one of its purposes is: "the elimination of religious, racial, sexual discrimination and segregation from American medical institutions by means of an effective organization of the medical profession within the states and territories of the United States."

NATIONAL ORGANIZATION FOR WOMEN (NOW)* is the largest feminist organization in the United States. Fundamental to NOW's purpose is the right of women to control their own bodies and to determine if and when to bear children. Women's right to reproductive freedom impacts not only their right to privacy, but also their health and freedom.

NATIONAL ORGANIZATION FOR WOMEN LEGAL DEFENSE AND EDUCATION FUND (NOWLDEF) is a nonprofit civil rights organization that performs a broad range of legal and educational services nationally in support of women's efforts to eliminate sex-based discrimination and secure equal rights. NOWLDEF was founded in 1971 by the leaders of the National Organization for Women.

NATIONAL REPUBLICAN COALITION FOR CHOICE (NRCC), founded in 1989 in the wake of the *Webster* decision, is a nonprofit, political organization dedicated to the promotion of pro-choice candidates within the Republican party and the furtherance of a pro-choice platform.

NATIONAL SOCIETY OF GENETIC COUNSELORS (NSGC) is a professional membership organization representing more than 750 genetic counselors in North America. Founded in 1979, the NSGC adopted the following pro-choice policy in 1987: "the NSGC, as an organization, publicly supports a woman's right to reproductive freedom including her right to prenatal diagnosis and access to safe and legal abortion."

THE NATIONAL WOMEN'S CONFERENCE COMMITTEE, formerly the IWY Continuing Committee of the 1977 First National Women's Conference (Houston, Texas), is the nonprofit, all-volunteer Committee working to implement the National Plan of Action adopted by 2000 delegates representing every state and territory, mandated by Congress to adopt recommendations to advance the status of women of the United States and to monitor progress on this National Plan of Action. Guaranteeing reproductive freedom to all women is one of the twenty-five priority planks in the National Plan of Action. Four hundred seventy members were appointed to the IWY Continuing Committee. Currently we are joined in our advocacy for women's rights by fourteen statewide networks and many individual grassroots supporters.

NATIONAL WOMEN'S LAW CENTER is a Washington-based legal organization which has been working since 1972 to advance and protect women's legal rights. The Center's primary goal is to ensure that public and private sector practices and policies better reflect the needs and rights of women. The fundamental right to abortion recognized in *Roe* v. *Wade* is of profound importance to the lives, liberty, health, and safety of women throughout the country. Because of the tremendous significance to women of the freedom to choose whether to bear children, the National Women's Law Center seeks to preserve women's right to abortion.

NATIONAL WOMEN'S POLITICAL CAUCUS (NWPC) is a nonprofit organization supporting the appointment and election of women to public office. NWPC also supports legislative initiatives at the states and national levels to insure fairness and equity for all Americans. As an organization comprised of white women and women of color working together, we recognize and work to overcome the particular problems faced by women of color, particularly those who are poor, in receiving adequate health care and in safeguarding their right to choice in reproductive decisions.

NEW JERSEY WOMEN'S LAWYERS ASSOCIATION (NJWLA) is a statewide independent bar association made up of direct membership and county women's bar affiliate associations throughout the state. The purposes of the NJWLA are to comment and testify on legislation affecting women, endorse and promote the selection of women to appointments to the judiciary and other positions of leadership and to maintain liaisons with other women's professional and business organizations.

NEW ORLEANS ASSOCIATION FOR WOMEN ATTORNEYS is an organization comprised of lawyers and judges, female and male, from the greater New Orleans area. Our organization is dedicated to the advancement of women in the legal

profession and the promotion and protection of legal rights for all women in our community. Our membership recently voted eighty-four percent to sixteen percent to adopt a pro-choice position. Accordingly, in an effort to promote legal rights of women in our society, we join this brief.

NEW YORK CITY COMMISSION ON THE STATUS OF WOMEN was established by Mayoral Executive Order in 1975 to advise the Mayor of New York City on issues affecting the city's 3.5 million women, to support and promote the rights of women in the private and public sectors of New York City and to advocate change to promote women's equality. In carrying out this mandate the Commission reviews and advocates for and against legislation at the Federal, State and City levels.

NEW YORK STATE COALITION AGAINST DOMESTIC VIOLENCE* is a membership organization of battered women's shelters, safe home projects, counseling and advocacy organizations and individuals committed to empowering women and helping them to lead violence-free lives. The Coalition believes in women's rights to choice and in the accessibility of services to all women, regardless of economic status. This includes every woman's right to reproductive choice and to medical assistance.

NEW YORK STATE COALITION ON WOMEN'S LEGAL ISSUES (COWLI) is a statewide organization established to identify and eradicate gender bias which is pervasive in our society. Among its other purposes, COWLI offers practical and substantive expertise and commentary on the effects on women of existing laws and proposed legislation. COWLI also provides special assistance to the courts by drawing attention to the deleterious effects on women of biased implementation of laws. COWLI is particularly concerned with these cases because they focus on the critical issue of reproductive freedom. COWLI is committed to ensuring reproductive freedom for all, as well as gender equality in the courts.

NEW YORK STATE REPUBLICAN FAMILY COMMITTEE is an educational advocacy organization devoted to promoting policies that foster maximum individual liberty and freedom of

choice, particularly in matters of health. Founded in 1984, the Committee has over 300 Republican party members with ninety-nine percent residing in New York State. Its membership includes lawyers, health care professionals, business people, educators, philanthropists, and numerous civic and political leaders.

NEW YORK UNIVERSITY LAW WOMEN is an organization of female law students. As a legal organization for women, we are committed to maintaining legal rights for other women and for ourselves. Through such projects as the Battered Women's Project and the Women in Prison Project, we face the inequitable treatment of women of color and low-income women by the legal system. On behalf of ourselves as women of a variety of races and income levels and on behalf of those we seek to assist, we strongly oppose any further restrictions on the rights of women to take control of their own lives and bodies.

NEW YORK WOMEN IN CRIMINAL JUSTICE* is an organization of women whose members include police, probation and correction officers; judges, attorneys, and social workers; others who work in the criminal justice system; inmates and ex-offenders. Our main concerns are that offenders who go through the system not come out worse than when they went in, and that as many offenders as possible be diverted from the system. We also strongly support the right of a woman to choose abortion, knowing that the offspring of women in prison become the dysfunctional children in school and often the criminals of the future. The right to abortion should not be restricted to only those women who can afford abortions (whether or not they remain legal); the right to choose should be available to all women, most especially those who understand the heavy burden that would be imposed upon both the children and the women in and just out of prison.

NORTH CAROLINA ASSOCIATION OF WOMEN ATTORNEYS (NCAWA) is a nonprofit corporation founded in 1978 whose objects are the promotion of the participation of women in the legal profession and the promotion of rights of women under the law. The NCAWA has been instrumental in the pas-

sage of laws affecting women on issues such as domestic violence, equitable distribution of marital property, and child support enforcement. There are approximately 1700 women attorneys in North Carolina and almost one third of all new applicants are women. We believe it is the obligation of all women attorneys, as well as the stated objective of our organization, to act as advocates for women's rights. In 1979 the NCAWA adopted a resolution endorsing the right of all women to exercise their reproductive freedom to carry their pregnancies to term with adequate prenatal care or to have an abortion. Based on this resolution and on our objectives, the NCAWA joins in this *amicus* brief.

NORTH CAROLINA EQUITY (NCE)* is a nonprofit organization dedicated to the economic advancement of women. NCE serves as a catalyst on women's issues and advances networking of women. We support women's full realization and exercise of their most basic legal rights, including a woman's right to control her own body. This right must include her right to choose abortion.

NORTHERN PROVINCE, MORAVIAN CHURCH IN AMERICA believes in the sacredness of life and in the quality of life, and that abortion should not be used as a method of birth control nor as a means of controlling population and that the Christian faith calls us to reaffirm the freedom of persons as well as the sanctity of life, the members of the Moravian Church believe that abortion should be a matter of responsible personal decision, with continuing counseling provided if desired.

NORTHWEST WOMEN'S LAW CENTER is a private, nonprofit organization in Seattle, Washington, that works to advance the legal rights of women by means of litigation, legislation, education and providing information and referrals. Protecting women's freedom of reproductive choice is one of the Law Center's priority issue areas. The Law Center has participated in several cases involving reproductive rights before the United States Supreme Court and other courts.

PATHFINDER FUND, founded in 1957 and based in Watertown, Massachusetts, is dedicated to ensuring the availability of family planning services throughout the developing world. Its activities include the development of new service delivery mechanisms, local institution building, training health care providers, and providing contraceptive supplies. In both the United States and overseas, it addresses public policy issues that affect the availability of safe and effective family planning services.

PEOPLE FOR THE AMERICAN WAY (PFAW), is a nonpartisan, education-oriented citizen's organization established to promote and protect civil and constitutional rights. Founded in 1980 by a group of religious, civic, and educational leaders devoted to the nation's heritage of tolerance and pluralism, PFAW now has 275,000 members nationwide. The organization's primary mission is to educate the public on the vital importance of the democratic tradition and to defend it against attacks from those who would seek to limit our constitutional and civil liberties enshrined in the Bill of Rights, particularly our First Amendment and privacy rights.

POPULATION COMMUNICATION is an international, nonprofit organization which communicates population and environmental messages to world leaders through books, reports, mailings, news releases, and motion pictures. During the last twelve years, it has obtained the support of forty-eight world leaders for a Statement of Population Stabilization.

POPULATION CRISIS COMMITTEE (PCC), based in Washington, D.C., seeks to increase public awareness of the need for the reduction of population growth rates through voluntary family planning. PCC supports privately funded projects in developing countries that provide medical training in the treatment of abortion complications and menstrual regulation procedures. PCC conducts authoritative analyses of United States population assistance programs, one of which has been a comprehensive study of the impact of current United States abortion restrictions on family planning programs overseas.

POPULATION SERVICES INTERNATIONAL is a nonprofit organization that provides contraceptive and health marketing

and communications services in several developing countries. As such, it has a particular concern for the limitations that prevent individuals from learning about, or choosing, family planning.

QUEEN'S BENCH OF THE SAN FRANCISCO BAY AREA* is a bar association in the San Francisco area designed to promote the interests of women attorneys. Founded in 1921, it has almost 700 members. Queen's Bench is joining this brief because of its concern in maintaining the fundamental legal principles affecting women that were established in *Roe* v. *Wade*.

RADICAL WOMEN is the oldest socialist feminist organization in the United States. Formed in 1968, it has eight United States branches and one in Australia. The community-based organization includes working women, young and elderly women, women of color, and lesbians. The battle for women's rights, including the right to safe and accessible abortions, is crucial to women's equality, socially, politically, and economically. The right to abortion is a fundamental right of privacy and for the Court to interfere is a grave injustice. The abolition of *Roe* v. *Wade*, or any changes whatsoever, will especially affect low income women, namely women of color, who will not be able to obtain private services found by other women who can afford to pay.

RAINBOW LOBBY is an independent citizen's lobby working to strengthen and preserve democracy nationally and internationally. The majority of people in the United States support the right of a woman to choose abortion. The Lobby is concerned about the enormous gap between the concerns of the majority of people in this country, i.e., for abortion rights for all women, and the public policy actually legislated by Congress. Our elected officials are more and more unaccountable to ordinary citizens, their constituents, and thus we don't hear any outcry from Congress against the Court's decision in *Webster*. The pro-choice majority in this country support *Roe* v. *Wade*. That position needs to be reflected in our public policy.

RELIGIOUS COALITION FOR ABORTION RIGHTS is composed of thirty national religious organizations—Protestant, Jewish, and other faith groups. We hold in high respect the value of potential human life; we do not take the question of choice lightly. Because each denomination and faith group represented among us approaches the issue of choice from the unique perspective of its own theology, members hold widely varying viewpoints as to when abortion is morally justified. It is exactly this plurality of beliefs which leads us to the conviction that the abortion decision must remain with the individual, to be made on the basis of conscience and personal religious principles, and free from governmental interference. Therefore we reaffirm the Supreme Court ruling of 1973, *Roe* v. *Wade*, which permits a woman to make a decision regarding abortion based on her own conscience and religious beliefs. We oppose efforts to enact into secular law one particular religious doctrine on abortion or the beginning of human life.

REPRODUCTIVE HEALTH SERVICES (RHS) is a Missouri nonprofit, federal tax exempt corporation with its principal office in St. Louis, Missouri. RHS offers to its patients a broad range of counseling, gynecological and family planning services, including the provision of contraceptive and abortion services. RHS provides abortion services up to twenty-one weeks "gestational age," up to one-third of which are offered at a reduced fee, and is the largest abortion provider within the State of Missouri.

ROUTH STREET WOMEN'S CLINIC, subscribes to the general statement of interest of *amici*, *supra*, at p. 2.

SAN FRANCISCO WOMEN LAWYERS ALLIANCE* is a progressive, activist bar association that was founded in 1983 to provide a vehicle through which women lawyers could address women's issues and enhance the position of women in our society. One of the issues of particular concern to our membership is freedom of choice and reproductive rights for all women.

SANTA BARBARA WOMEN'S POLITICAL COMMITTEE (SBWPC) is a political action committee with over 300 members. SBWPC was formed in 1987 with a commitment to

increasing the role of women in the political and governmental processes of Santa Barbara and the state of California. The Committee is also committed to furthering the interests of women as a group through the political process. Issues such as reproductive choice, pay equity and child care are central to our concerns. Because the protection of the constitutional right of reproductive choice is our top priority for 1989, we are especially interested in the resolution of *Ragsdale* and *Akron* by the United States Supreme Court.

SIERRA CLUB, founded in 1982, is a nonprofit conservation organization with approximately 500,000 members nationwide. The goals of the Sierra Club are, among others, to participate and promote responsible uses of the earth's ecosystems and resources, and to educate and enlist all people to protect and restore the quality of the natural and human environment. The Sierra Club's interest in the right of reproductive choice is based on the longstanding belief that achieving population stabilization is essential for the long-term protection of the environment in every nation of the world, including the United States.

SOUTHERN CALIFORNIA WOMEN'S LAW CENTER (SCWLC) was established in 1989 as the first Law Center in Southern California devoted solely to the civil rights of women and girls. Protection of the right to reproductive freedom contained in the Constitution is one of the most significant legal issues facing women today. The SCWLC has a significant interest in the current appeals and extensive background in the issues presented to the Court.

SOUTHERN CHRISTIAN LEADERSHIP CONFERENCE (SCLC) is an international, civil and human rights organization, composed of individual members, chapters, and affiliates. Founded in 1957, by the Reverends Martin Luther King, Jr., Joseph E. Lowery, and Ralph Abernathy, the SCLC is committed to the advancement of minorities and disadvantaged people in American society and the world, so as to ensure full participation in the social, economic, educational, and political arenas. SCLC works to achieve this mission through nonviolent means, which include litigation and demonstration. We,

SCLC, join this brief in recognition that the right of planned parenthood, whether and when to have children, is an integral part of the attainment of civil rights and should be fully guaranteed by the Supreme Court as the arbiter of our constitutional rights.

ST. LOUIS CATHOLICS FOR CHOICE sees decisions about reproduction as a very important aspect of our moral lives and separate from our decisions about our sexual lives. We see the availability of safe legal abortions as necessary for practical and humanitarian reasons. We value motherhood too highly to view it merely as a biological process which must not be interrupted once started. We affirm women as fully human, competent moral agents capable of making responsible choices in matters of reproduction.

STUDENTS AND YOUTH AGAINST RACISM* is a national organization based in New York City with chapters nationwide whose women members include students and youth from many communities. It supports the right of all women to terminate a pregnancy through abortion, without restrictions, if they so choose. To deny safe, legal abortion would seriously harm the health of and discriminate against untold numbers of young women, especially the poor, unemployed, and Black, Latino, Asian, and Native Americans, who, without the funds to obtain safe abortions, would have to resort to dangerous health-threatening procedures.

TARRANT COUNTY, TEXAS CHOICE NETWORK is a coalition formed in 1983 and dedicated to keeping abortion safe and legal and to assuring reproductive freedom for all women, regardless of age or economic status.

TRANSNATIONAL FAMILY RESEARCH INSTITUTE (TFRI) is a multidisciplinary, nongovernmental, and nonprofit research organization in the behavioral sciences. TFRI develops and conducts research in reproductive behavior, often in cooperation with colleagues abroad. Research interests focus on the behavioral regulation of fertility, motivations for pregnancy resolution, and the decision making process. TFRI currently has offices in Palo Alto, California; Copenhagen, Denmark;

Mexico City, Mexico; and Bangkok, Thailand. Since 1972, the Institute has published *Abortion Research Notes*, reviewing scientific literature related to pregnancy termination.

TUSCON WOMEN'S COMMISSION* was founded in late 1975 by the Mayor and Council of the City of Tuscon to assist women in attaining full equality of all opportunity in all aspects of life. The Commission also maintains that public policy in the best interest of women will support a full range of options, information, and services so that every woman has the ability to make her own decision about when, whether, and under what conditions to bear a child.

UNION OF AMERICAN HEBREW CONGREGATIONS (UAHC) is the national congressional body of Reform Judaism comprising approximately 1.3 million members from over 830 Reform synagogues throughout the United States and Canada. To deal with issues of public policy, UAHC maintains a Commission on Social Action in cooperation with other arms of Reform Judaism. At its 1975 biennial convention, General Assembly delegates voted overwhelmingly to support the constitutional right of a woman to obtain an abortion if she freely chooses to do so, as determined by the Supreme Court in the 1973 landmark decisions of *Roe* v. *Wade* and *Doe* v. *Bolton*. In 1981, at the fifty-sixth General Assembly of the UAHC the delegates reaffirmed this position declaring that women must be free to exercise their moral and religious conscience regarding abortion.

UNITARIAN UNIVERSALIST WOMEN'S ASSOCIATION (UUWA) is a voluntary religious association of 1000 congregations in the United States and abroad dedicated to the principles of free faith, the right to an individual conscience and to the promotion of the inherent worth and dignity of every person. UUWA has long advocated the right of every woman to decide whether she should bear a child. We believe that the issue of abortion is morally complex and thus must be decided by each individual and remain a legal option. UUWA firmly believes that circumscription or prohibition of the right to terminate a pregnancy by qualified medical practitioners is an affront to

human life and dignity. In the last two decades, UUWA has repeatedly affirmed its belief that women of any age or marital or economic status have the right to have an abortion upon medical/social consultation of her choosing.

UNITED CHURCH OF CHRIST BOARD OF HOMELAND MINISTRIES, See statement below.

UNITED CHURCH OF CHRIST COORDINATING CENTER FOR WOMEN, See statement below.

UNITED CHURCH OF CHRIST OFFICE OF CHURCH AND SOCIETY (UCC) has, for almost two decades, supported a woman's right to choose safe, legal abortions and we deplore the willingness of many legislators, at all levels, to restrict the access of poor women to safe, comprehensive reproductive health care with a full range of options. Therefore, the seventeenth General Synod of the UCC reaffirms its historic and courageous leadership in support of freedom of choice as legally supported by *Roe* v. *Wade*, and urges all parts of the church to work toward a society where the full range of reproductive options are available to all women regardless of economic circumstances and to address the root causes that lead to unplanned pregnancies and lack of life options. Furthermore, the UCC deplores the *Webster* decision and believes that the decision severely limits major provisions of *Roe* v. *Wade*, undermining the spirit of the constitutional freedom of choice of women in this nation and making freedom of choice essentially a luxury for those who are not economically disadvantaged.

UNITED LABOR ACTION* is a national network of unionists, labor activists and unemployed workers, whose members, including many women, are of all nationalities who organize for workers' rights, with special concern for the poorest and unorganized. It supports the right of working women to have their right to privacy in making personal decisions about their lives as one aspect of having an equal place at the work place and in society. It views that working women must be guaranteed choice in reproductive matters with safe, legal, affordable abortions, Medicaid funding, if needed, and decent jobs, pay

equity, child care, parental leave and low cost health care in order to decide whether or when to have children. Poor and working women have always had abortions; many died as a result prior to 1973. To deny this right would hurt millions of working women, especially the poorest—service workers, part-time and temporary workers, and minimum-wage earners, of which sixty percent are women. It would fall most heavily upon and discriminate against Black, Latina, Asian and Native American women who form a disproportionately high number of the poorest workers and would again be forced to resort to unsafe abortions.

UNITED METHODIST CHURCH, CENERAL BOARD OF GLOBAL MINISTRIES, WOMEN'S DIVISION, a program agency of The United Methodist Church, which has 9.5 million members, has a strong commitment to women and to the right of women to make decisions such as abortion decisions. The Church's position affirms the Supreme Court decision in *Roe* v. *Wade*, believing that abortion should be a safe and legal procedure, and that a decision about abortion should be made by a woman after prayerful consideration with the assistance of persons she may choose. We believe that abortion should not be used for birth control nor gender selection, but recognize "tragic conflicts of life with life that may justify abortion, and in such cases support the legal option of abortion under proper medical procedures."

UNITED STATES STUDENT ASSOCIATION (USSA)* is a nationwide nonprofit membership organization which represents approximately two million students at approximately 200 colleges and universities throughout the United States. USSA has a strong commitment to ensuring access to higher education and the right to self-determination for all individuals regardless of age, gender, economic status, race, disability, sexual/affectional orientation, or veteran status.

UNITED SYNAGOGUE OF AMERICA (USA), founded in 1913, is the association of Conservative Congregations in North America, today consisting of 850 affiliated synagogues and over 1.5 million members. The USA affirms once again its position that "abortions involve very serious psychological, religious, and moral problems, but the welfare of the mother must always be our primary concern."

UNIVERSITY OF CONNECTICUT WOMEN'S CENTER is committed to creating a social, economic, and political world that supports the full equity for women. Without unrestricted access to abortion for women of all ages, equity cannot be achieved. Continued attacks aimed at limiting women's access to reproductive freedoms are directly contrary to establishing a system whereby women are afforded equal protection under the law.

VOTERS FOR CHOICE is a national, independent, pro-choice political action committee. The mission of Voters for Choice is to preserve safe and legal abortion for all women by helping elect pro-choice candidates to United States Congress.

WASHINGTON WOMEN UNITED (WWU) founded in 1978, is a private nonprofit organization whose purpose is to lobby the Washington state legislature on issues of concern to women. Reproductive choice is WWU's first legislative priority. The organization has opposed state legislation that would limit a woman's reproductive choice. WWU is also active in a state coalition that has worked to maintain Medicaid funds for abortion.

WIDER OPPORTUNITIES FOR WOMEN supports the *amicus* brief because of our twenty-five year history working for equality of opportunity and economic self-sufficiency for women and girls. We urge the Court to uphold women's right to choose abortion.

WOMEN AND LAW IN SOUTHERN AFRICA is a regional organization doing research into women's legal rights in Southern Africa. As such, abortion laws are a major concern for us. Our interest in the cases is that our courts sometimes refer to United States judgments when deciding local cases.

WOMEN EMPLOYED is a national organization of working women, based in Chicago, with a membership of 1500. Over the past sixteen years, the organization has assisted thousands of

working women with problems of sex discrimination. Women Employed works to empower women to improve their economic status and to remove barriers to economic equality through advocacy, direct service, and public education. Women Employed strongly believes that any limitation on women's reproductive rights will have a profoundly negative impact on women's opportunities to achieve economic equity.

WOMEN IN CRISIS COMMITTEE OF THE EPISCOPAL DIOCESE OF MASSACHUSETTS objects strongly to any governmental attempts to interfere in the exercise of individual religious conscience with regard to procreative choice. Because we recognize the many divergent theological answers to the questions raised by abortion, we agree that each woman should be free to consult with her religious convictions, as well as her best medical advice, without governmental coercion or constraint when exercising religious and personal conscience in making a decision whether to terminate her pregnancy. We further consider restrictions on access to medical care based on ability to pay inequitable.

WOMEN LAWYERS ASSOCIATION OF LOS ANGELES (WLALA),* founded in 1919, is the largest local bar association in the State of California emphasizing the concerns of women. WLALA has as members over 1200 female and male lawyers, judges, and law students who are personally and professionally concerned with the importance of preserving a woman's right to choose for herself whether to terminate a pregnancy.

WOMEN LAWYERS ASSOCIATION OF MICHIGAN is an 1100 member professional association, founded in 1919 for the purposes of securing the rights of women in society, advancing the interests of women lawyers, improving the administration of justice, and promoting equality and social justice for all people. It adopted a pro-choice policy many years ago, believing it fundamental that constitutional privacy rights protect individuals from governmental intrusion into reproductive decision-making.

THE WOMEN OF COLOR PARTNERSHIP PROGRAM OF THE RELIGIOUS COALITION FOR ABORTION RIGHTS, located in Washington, D.C., is a national effort to educate women of color concerning public policies surrounding the issue of reproductive choice and its disproportionate affect on women of color. This program seeks to identify and address not only reproductive rights issues but also reproductive health care concerns from the unique perspective of women of color to include: (1) the right to choose or not to choose abortion; (2) family planning and all methods of birth control; (3) teen pregnancy; (4) prenatal care; (5) child care; and (6) medical abuses against women of color. We are concerned about the numerous public policies which create a negative impact on the ability of women of color to make a difficult decision, the unnecessary sacrifices that she and her family may have to make because of a lack of resources and the degradation that she must undergo to carry out her decision. We believe that *all* women, regardless of race or class, should have access to a safe and legal abortion.

WOMEN USA is an organization that seeks to encourage more widespread understanding and awareness of current social, economic, legal, political, cultural, educational, and other issues affecting the condition and status of women in the United States.

WOMEN'S ACTION ALLIANCE, INC.,* in New York City, works extensively with community based organizations serving women of color, young women, and low-income women. We are keenly aware of the importance of maintaining a full range of reproductive options for these and all women. If abortion services or access to abortion were to be restricted, these women would have no alternative but to seek dangerous alternatives to safe and legal abortion.

WOMEN'S ALLIANCE THEOLOGY, ETHICS AND RITUAL (WATER) is a nonprofit educational center that empowers women and men to be religious agents. The co-founders/co-directors work with an interfaith team of ministers, activists and professors to bring about change and move toward inclusivity in church and society. Through programs,

projects and publications, WATER provides women and men with resources to foster equality and create a "discipleship of equals." WATER signs the *amicus* brief because the organization is committed to equality and choice for all women, especially for poor women. The many religious questions raised by the case are precisely the kinds of issues that WATER considers central to understanding and guaranteeing religious agency. WATER constituents come from a variety of backgrounds and sets of beliefs on reproductive rights. But the values of free discussion, legal options and religious pluralism are prized among us. We urge this for society as a whole.

WOMEN'S AMERICAN ORT has long held a pro-choice position on the issue of reproductive freedom, and believes that any erosion of rights will be corrosive to fundamental individual liberties. ORT and its 145,000 members believe that when and whether to bear a child is a woman's private decision and opposes attempts to narrow the opportunity for women to control their own lives and be free from all levels of governmental intervention.

WOMEN'S BAR ASSOCIATION OF ILLINOIS (WBAI)* was founded in 1914 for the purpose of promoting and fostering the interests and welfare of women and women attorneys and to maintain the honor and dignity of the legal profession. WBAI's 1000 members have long campaigned for individual rights and liberties, including the right of women to make reproductive decisions free from governmental interference. WBAI has filed briefs *amicus curiae* before this Court on behalf of parties whose rights were in jeopardy.

WOMEN'S BAR ASSOCIATION OF MASSACHUSETTS (WBA)* is a statewide bar association of over 1000 members. The WBA is committed to the advancement of women attorneys and to the protection of all women in the legal system. Since its founding in 1978, the WBA has been particularly concerned with the protection of a woman's right to choice. It has filed *amicus* briefs in cases concerning public funding of abortion, restrictions on family planning agencies, and the rights of minors to abortion. The WBA also sponsors a panel of attorneys who represent minors seeking judicial consent for abortion and is a member of the Massachusetts Coalition for Choice.

WOMEN'S BAR ASSOCIATION OF THE DISTRICT OF COLUMBIA (WBADC) is a membership organization of 1900 male and female attorneys who practice law in the District of Columbia. The WBADC has a continuing concern that safe choices should be available to all women about whether, and under what circumstances, to have children. The restrictions at issue in the referenced matters threaten the availability of those safe choices.

WOMEN'S BAR ASSOCIATION OF THE STATE OF NEW YORK (WBASNY) (which includes: the women's bar associations of Bronx County, Brooklyn, Capital District, Central New York, Mid-Hudson, Nassau, Orange/Sullivan, Queens, Greater Rochester, Rockland, Staten Island, Westchester, and Western New York) is an organization of over 3000 attorneys throughout the state. Founded in 1980, its stated purposes include the following: to cooperate with, aid and support organizations and causes which advance the status and progress of women in the society; to facilitate the administration of justice; and to cultivate the science of jurisprudence. The members of WBASNY support the principles enunciated in *Roe* v. *Wade*, including the recognition of a constitutionally guaranteed right to privacy.

WOMEN'S BUSINESS DEVELOPMENT CENTER subscribes to the general statement of interest of *amici*, *supra*, at p. 2.

WOMEN'S CITY CLUB OF NEW YORK, founded in 1916, is a membership organization concerned with contemporary societal programs—with the welfare of men, women, and children, in promoting such welfare by advocacy of an efficient government and a just legal system. We are concerned with these cases for the following reasons: we feel that the principle established in *Roe* v. *Wade* was a step forward in establishing the freedom of women for domain over their own bodies and that any step backward is a challenge to that freedom and the equality of women in our society.

WOMEN'S ELECTORAL LOBBY AUSTRALIA (WELA), formed in 1972, is a voluntary organization of women committed to the goal of achieving economic, educational and sexual equality for women. WELA is committed to promoting the status of women and regards the right to fertility control, including safe abortion, as fundamental to women's ability to live healthy and meaningful lives.

WOMEN'S EQUAL RIGHTS LEGAL DEFENSE AND EDUCATION FUND (WERLDEF) is a nonprofit California corporation. Established in 1978, WERLDEF was organized to ensure that women will be treated equally under the law. We achieve our goals by educating women about their legal rights, and assisting them in vindicating those rights by providing access to the courts. WERLDEF often receives calls from women who are pregnant and in crisis because they are neither financially nor emotionally able to raise a child and who are psychologically unable to carry their pregnancy to term and put their baby up for adoption.

WOMEN'S EQUITY ACTION LEAGUE (WEAL) was founded in 1968 as a national, nonprofit membership organization sponsoring research, education, litigation, and advocacy in order to advance the economic status of women. WEAL supports and recognizes a woman's constitutional right to reproductive choice. Basic to a woman's economic empowerment is the right to make a fully informed decision regarding the planning of her family.

WOMEN'S LAW CENTER, is an advocacy organization in the State of Maryland whose goal is to promote the legal rights of women through litigation, legislation and education. Our organization sees the privacy and reproductive rights issues raised in the *Akron* and *Ragsdale* cases as critical to the advancement of women's rights, and, indeed, as critical to preventing the loss of legal rights gained over the last sixteen years since the *Roe* v. *Wade* decision.

WOMEN'S LAW PROJECT (WLP)* is a nonprofit law firm dedicated to advancing the status and opportunities of women. WLP believes that the right to reproductive choice is an essential component of women's ability to play an equal role with men in this society, and has engaged in extensive litigation and public education designed to protect women's legal right to abortion.

WOMEN'S LEAGUE OF CONSERVATIVE JUDAISM,* founded in 1918, is an international organization of Jewish women which is associated with the Jewish Theological Seminary and works closely with the United Synagogue of America and the World Council of Synagogues. It is dedicated to the perpetuation of traditional Judaism in our modern society and the translation of its high ideals into practice through living Judaism in the home, the Synagogue and the community. Because reverence for life is the cornerstone of the Jewish heritage, it believes that abortion should be 'legally available, but ethically restricted.'

THE WOMEN'S LEGAL DEFENSE FUND (WLDF) is a nonprofit national advocacy organization of over 2500 members dedicated to challenging sex discrimination and to advancing women's concerns through the legal system. WLDF believes that reproductive freedom is fundamental to women's achievement of equality in society. Therefore WLDF makes this issue one of its highest priorities and has a long history of activism and legislative and judicial advocacy in this area.

WOMEN'S ORDINATION CONFERENCE, subscribes to the general statement of interest of *amici*, *supra*, at p. 2.

WOMEN'S RIGHTS COALITION is an active legislative effort composed of more than sixty local and statewide organizations across the State of Oregon. Founded in 1973, the Coalition brings together a wide range of service, professional, and advocacy groups who have the common belief that Oregon women should have equal rights and reproductive freedom.

WORKERS WORLD PARTY* is a national multi-chapter organization based in New York City whose members include working and poor women, youth, lesbians, seniors, disabled, unemployed and women on fixed incomes. It believes that every woman must be guaranteed choice and privacy regarding the

critical and very personal issue of whether or when to have children and the right to control their own reproduction. To deny this fundamental right to make the most personal decisions about their lives reinforces their subordinate status in society. Additionally it further burdens young, poor, Black, Latina, Asian and Native American women, who would have even fewer choices if legal abortion is overturned, and who, furthermore, would face a disproportionately higher number of complications by having to resort to unsafe abortionists or self-induced procedures.

WORLDWATCH INSTITUTE is an independent, nonprofit research organization established to alert decision-makers and the general public to emerging global trends in the availability and management of both human and natural resources. Population and family planning issues have been a central concern at Worldwatch since its founding in 1974.

YALE JOURNAL OF LAW AND FEMINISM is a nationally circulated journal dedicated to addressing feminist issues in law and legal scholarship. Preservation of the legal right to abortion is central to our concerns because a woman's control over her body is a necessary starting point for our broader concerns about the status of women in society.

YOUNG WOMEN'S CHRISTIAN ASSOCIATION OF THE U.S.A. (YWCA) is a national membership movement, headquartered in New York City, that serves two million women and their families. The YWCA draws together women and girls of diverse experiences so that their lives may be open to new and deeper relationships and that together they may join in the struggle for peace and justice, freedom and dignity for all people. The YWCA is dedicated to the empowerment of women and the elimination of racism.

APPENDIX B

AD HOC COMMITTEE OF AMERICAN HISTORY PROFESSORS

Nina S. Adams, Sangamon State University
Jean-Christophe Agnew, Yale University
Gabriel A. Almond, Stanford University
Kenneth L. Ames, Winterthur Museum
Susan Dwyer Amussen, Connecticut College
Bonnie S. Anderson, Brooklyn College
M. Christine Anderson, University of Cincinnati
Lee Anderson, University of Iowa
Toby A. Appel, University of Maryland-Baltimore
Rima D. Apple, University of Wisconsin
Jo Ann E. Argersinger, University of Maryland-Baltimore
Peter H. Argersinger, University of Maryland-Baltimore
Susan Armitage, Washington State University
Cindy S. Aron, University of Virginia
Barri Y. Babow, University of Wisconsin
Alison Baker, New York University
Lois W. Banner, University of Southern California
Martha Banta, University of California at Los Angeles
G. J. Barker-Benfield, State University of New York, Albany
Elizabeth Lynne Beavers, University of Wisconsin
Susan Behuniak-Long, Le Moyne College
Rudolph M. Bell, Rutgers University
Thomas Bender, New York University
Judith M. Bennett, University of North Carolina
Daniel R. Benson, Johns Hopkins University
Frederick M. Binder, City University of New York, Staten Island
Anne-Emanuelle Birn, Johns Hopkins University
Rebecca Boehling, University of Maryland-Baltimore
Janet Carlisle Bogdan, Le Moyne College
Eileen Boris, Howard University
Jeanne Boydston, University of Wisconsin
Allan M. Brandt, Harvard University

Renate Bridenthal, City University of New York, Brooklyn
Gregory M. Britton, University of Wisconsin
Elizabeth A. R. Brown, City University of New York, Brooklyn
JaNae Brown, University of Wisconsin
Judith C. Brown, Stanford University
Joan Jacobs Brumberg, Cornell University
Vern L. Bullough, State University of New York, Buffalo
E. Jane Burns, University of North Carolina
Edwin G. Burrows, Brooklyn College
Caroline Walker Bynum, Columbia University
Pat Calchina, University of Wisconsin
Susan E. Cayleff, San Diego State University
Jane Turner Censer, George Mason University
Jack R. Censer, George Mason University
Clarke A. Chambers, University of Minnesota
Herrick Chapman, Carnegie Mellon University
Ellen Chesler, Barnard College
Patrick M. Chiasson, Johns Hopkins University
Eric H. Christianson, University of Kentucky
Jill N. Claster, New York University
Paul G. E. Clemens, Rutgers University
Miriam J. Cohen, Vassar College
Paul A. Cohen, Wellesley College
Maureen S. Conklin, University of Wisconsin
Harold J. Cook, University of Wisconsin
Frederich Cooper, University of Michigan
Sarah E. Cooper, City University of New York, Staten Island
Dawn L. Corley, University of Wisconsin
Joseph J. Corn, Stanford University
Wanda M. Corn, Stanford University
Nancy F. Cott, Yale University
Elaine Forman Crane, Fordham University
Virginia G. Crane, University of Wisconsin-Oshkosh
James G. Crawford, University of North Carolina
Nancy J. Curtin, Fordham University
Daniel Czitrom, Mount Holyoke College
Christine M. Dacier, Historical Society of Pennsylvania
Norman Daniels, Tufts University
Pete Daniel, National Museum of American History

Margaret H. Darrow, Dartmouth College
David Brion Davis, Yale University
Mollie C. Davis, Queens College
Natalie Zemon Davis, Princeton University
Philip Dawson, City University of New York, Brooklyn
Hannah S. Decker, University of Houston
Jane S. DeHart, University of North Carolina
Roberta E. Dell, Historical Society of Pennsylvania
Marion F. Deshmukh, George Mason University
Jane B. Donegan, Onondaga Community College
John E. Dowling, Harvard University
Ellen Carol DuBois, University of California at Los Angeles
Brian R. Duchin, Williams College
Arthur P. Dudden, Bryn Mawr College
Colleen Dunlavy, University of Wisconsin
Barbara Engel, University of Colorado
Lewis A. Erenberg, Loyola University
Sara M. Evans, University of Minnesota
John M. Eyler, University of Minnesota
Leslie Falk, Meharry Medical College
Elizabeth Fee, Johns Hopkins University
Bruce R. Fehn, University of Wisconsin
Mary L. Felstiner, San Francisco State University
Eileen J. Findlay, University of Wisconsin
Joyce Follet, University of Wisconsin
John Hope Franklin, Duke University
Joshua Freeman, Columbia University
Andrea Friedman, University of Wisconsin
Estelle B. Freedman, Stanford University
Vanessa Northington Gamble, University of Wisconsin
Sheldon Garon, Princeton University
Faye Marie Getz, University of Wisconsin
Mary S. Gibson, John Jay College of Criminal Justice
Timothy Gilfoyle, Loyola University of Chicago
Faye Ginsburg, New York University
Judith R. Ginsburg, Cornell University
Lori D. Ginzberg, Penn State University
Carol Gluck, Columbia University
Janet Golden, Temple University

Elise Goldwasser, Duke University
Linda Gordon, University of Wisconsin
Elliot J. Gorn, Miami University
Douglas Greenberg, American Council of Learned Societies
Barbara J. Greene, Johns Hopkins University
Monica H. Green, Duke University
Paul Greenough, University of Iowa
Ronald J. Grele, Columbia University
Clyde Griffen, Vassar College
Gerald N. Grob, Rutgers University
Carol Groneman, John Jay College of Criminal Justice
Atina Grossman, Columbia University
Melanie Susan Gustafson, Sarah Lawrence College
Jacquelyn D. Hall, University of North Carolina
Marilyn Halter, Wellesley College
William A. Hamill, Historical Society of Pennsylvania
Michael P. Hanagan, Columbia University
Sarah Hanley, University of Iowa
Jon M. Harkness, University of Wisconsin
Louis R. Harlan, University of Maryland
Barbara J. Harris, University of North Carolina
Janine C. Hartman, University of Cincinnati
Thomas Hatch, Historian
Ellis W. Hawley, University of Iowa
John M. Headley, University of North Carolina
Dorothy O. Helly, Hunter College of the City University of New York
Cynthia B. Herrup, Duke University
Gail Hershatter, Williams College
Evelyn Brooks Higginbotham, University of Pennsylvania
Susan E. Hirsch, Loyola University
Christine Hoepfner, University of Pennsylvania
Joan Hoff-Wilson, Indiana University
David Hollinger, University of Michigan
Emily Honig, Yale University
Helen Horowitz, Smith College
Joel D. Howell, University of Michigan
Martha C. Howell, Columbia University
Suellen Hoy, University of Notre Dame

Karl Hufbauer, University of California at Irvine
Nathan I. Huggins, Harvard University
Lynn Hunt, University of Pennsylvania
Harold M. Hyman, Rice University
Joseph E. Illick, San Francisco State University
William Issen, San Francisco State University
Maurice Isserman, Williams College
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Sally Burnett Sharp, University of North Carolina School of Law
Michael R. Sheldon, University of Connecticut School of Law
Robert E. Shepherd, Jr., University of Richmond School of Law
Francine Sherman, Boston College Law School
Jeffrey G. Sherman, Illinois Institute of Technology, Chicago-Kent College of Law
Suzanna Sherry, University of Minnesota Law School
Daniel W. Shuman, Southern Methodist University School of Law
Marjorie A. Silver, New York Law School
Andrew Silverman, University of Arizona College of Law
Eileen Silverstein, University of Connecticut School of Law
Jana B. Singer, University of Maryland School of Law
Joseph W. Singer, Boston University School of Law
Norman J. Singer, University of Alabama School of Law
Eric S. Sirulnik, George Washington University National Law Center

John Snowden, University of Nebraska
Lloyd B. Snyder, Cleveland State University, Cleveland-Marshall College of Law
Frances Cappelletti Solari, North Carolina Central University School of Law
Rayman L. Solomon, Northwestern University School of Law
Robert A. Solomon, Yale Law School
Elizabeth K. Spahn, New England School of Law
Giradeau A. Spann, Georgetown University Law Center
Mark Spiegel, Boston College Law School
Mark Squillace, University of Wyoming College of Law
Barbara Stark, Rutgers State University School of Law
James H. Stark, University of Connecticut School of Law
Ralph Michael Stein, Pace University School of Law
Joan Steinman, Illinois Institute of Technology, Chicago-Kent College of Law
Jeffrey W. Stempel, Brooklyn Law School
Ann B. Stevens, University of Wyoming College of Law
Margaret Stewart, Illinois Institute of Technology, Chicago-Kent College of Law
Serena Stier, Albany Law School
Jan Stiglitz, California Western School of Law
Nomi Stolzenberg, University of Southern California Law Center
Albert W. Stone, University of Montana School of Law
Katherine Stone, Benjamin N. Cardozo School of Law
Kurt A. Strasser, University of Connecticut School of Law
Nadine Strossen, New York Law School
Stephen N. Subrin, Northeastern University School of Law
Kathleen A. Sullivan, Brooklyn Law School
Carol B. Swanson, Hamline University School of Law
Steven R. Swanson, Hamline University School of Law
Winnona Tanaka, The University of Tulsa College of Law
Nadine Taub, Rutgers State University School of Law
Sheila Taub, University of Bridgeport School of Law
George H. Taylor, University of Pittsburgh School of Law
David C. Thomas, Illinois Institute of Technology, Chicago-Kent College of Law

Elizabeth Thornburg, Southern Methodist University School of Law
Michael E. Tigar, University of Texas School of Law
Frank Tuerkheimer, University of Wisconsin Law School
Mark Tushnet, Georgetown University Law Center
Jon M. Van Dyke, University of Hawaii, W.S. Richardson School of Law
Dominick Vetri, University of Oregon School of Law
Diana Vincent-Daviss, New York University School of Law
Michael Vitiello, Loyola University School of Law
Howard J. Vogel, Hamline University School of Law
Valerie J. Vollmar, Willamette University College of Law
Kathleen Waits, Albany Law School
Heathcote W. Wales, Georgetown University Law Center
Manning Warren, University of Alabama School of Law
Rhonda Wasserman, University of Pittsburgh School of Law
Sidney Watson, Mercer University Law School
John Weeks, Hamline University School of Law
Burton D. Wechsler, American University, Washington College of Law
Janet Motley Weinstein, California Western School of Law
Robert Weisberg, Stanford Law School
June Weisberger, University of Wisconsin School of Law
Mary Moers Wenig, University of Bridgeport School of Law
Robert A. Weninger, Texas Tech University School of Law
Stephen J. Werber, Cleveland State University, Cleveland-Marshall College of Law
Keith Werhan, Tulane University School of Law
David Westfall, Harvard Law School
Lucie White, University of California at Los Angeles, School of Law
Wenona Yvonne Whitfield, Southern Illinois University School of Law
Shirley A. Wiegand, University of Oklahoma Law School
Stephanie Wildman, University of California, Hastings College of Law
Steven L. Willborn, University of Nebraska College of Law
Robert J. Willey, Cleveland State University, Cleveland-Marshall College of Law

David Williams, Cornell Law School
Patricia Williams, Stanford Law School
Robert F. Williams, Rutgers State University School of Law
Susan Williams, Cornell Law School
Wendy W. Williams, Georgetown University Law Center
Charles E. Wilson, Ohio State University College of Law
C. Keith Wingate, University of California, Hastings College of Law
Bruce J. Winick, University of Miami School of Law
Stephen Wizner, Yale Law School
Arthur D. Wolf, Western New England College School of Law
Bernard Wolfman, Harvard Law School
Charles W. Wolfram, Cornell Law School
Margaret Woo, Northeastern University School of Law
William J. Woodward, Jr., Temple University School of Law
Geri J. Yonover, Valparaiso University School of Law
Paul Howard Zarefsky, Santa Clara University School of Law
Amy C. Ziegler, St. Louis University School of Law
Luize E. Zubrow, George Washington University National Law Center

APPENDIX D

AD HOC COMMITTEE OF SCIENTISTS & PHYSICIANS

Frederick Abrams, M.D., Center for Health and Ethics Policy, University of Colorado
Stephen Adler, Institute for Advanced Study, Princeton University
Guentes Ahlers, Professor of Physics, University of California at Santa Barbara
E.H. Ahrens, Professor, Rockefeller University
Bruce Alberts, Chair, Department of Biochemistry, University of California at San Francisco School of Medicine
Gabriel A. Almond, Professor of Political Science, Stanford University
Dennis Amos, Duke University School of Medicine
Edward Anders, Professor of Chemistry, University of Chicago
Philip Anderson, Professor of Physics, Princeton University **(Nobel Prize)**
Theodore W. Anderson, Professor Emeritus of Economics and Statistics, Stanford University
Clay Armstrong, Professor of Physiology, University of Pennsylvania
Robert Austrian, Chairman Emeritus, Department of Research Medicine, University of Pennsylvania
George Backus, Professor of Geophysics, University of California at San Diego
John Backus, I.B.M. Fellow
David Baltimore, Director and Professor of Biology, Physiology, Whitehead Institute for Biomedical Research **(Nobel Prize, 1975)**
Allen Bard, Chair Department of Chemistry, University of Texas
Rabbi Terry R. Bard, Coordinator, Medical Ethics Program, Beth Israel Hospital, Massachusetts
Gail Amalia Barth-Katz, Director of Planning, Union Memorial Hospital, Baltimore, Maryland

Hyman Bass, Professor of Mathematics, Columbia University
Peter Bayhise, Director, Fertility Control Clinic, Brisbane, Australia
Jessie Beauchamp, Professor of Chemistry, California Institute of Technology
Jonathan Beckwith, Professor, Harvard University
Paul Beeson, Professor Emeritus of Medicine, University of Washington
Helmut Beinert, Professor of Biochemistry, Medical College of Wisconsin
Jeffrey Bell, Institute of Molecuar Biology, University of Oregon
Michael Bennet, Chair, Department of Neuroscience, Albert Einstein School of Medicine
Paul Berg, Director, Beckman Center, Stanford University Medical Center (Nobel Prize)
Robert W. Berliner, Professor Emeritus of Physiology and Medicine, Yale University
Robert Berne, Professor, University of Virginia
Richard Bersohn, Professor of Natural Science, Columbia University
Hans Bethe, Professor Emeritus, Cornell University (Nobel Prize)
Ernest Beutler, Chair, Department of Molecular and Experimental Medicine, Scripps Clinic and Research Foundation
Peter Bickel, Professor, University of California at Berkeley
Jacob Bigeleisen, Professor Emeritus, State University of New York
Emilio Bizzi, Chair, Department of Brain and Cognitive Sciences, Massachusetts Institute of Technology
Peter Blau, Professor, University of North Carolina
Gunter Blobel, Professor of Cell Biology, Rockefeller University
Herman Bloch, Consultant—Chemistry
Nicolaas Bloemberger, Professor, Harvard University (Nobel Prize, 1981)
Lawrence Bogorad, Professor of Biology, Harvard University

Kenneth E. Boulding, Professor Emeritus of Economics, University of Colorado
Edward Boyse, Professor of Microbiology, University of Arizona
Roscoe Brady, Branch Chief, National Institutes of Health
Myron Brakke, Professor Emeritus, University of Nebraska
Roy J. Britten, Carnegie Senior Research Associate, California Institute of Technology
Donald Brown, Director, Department of Embryology, Carnegie Institute of Washington
Roger Brown, Professor of Psychology, Harvard University
John Buchanan, Professor Emeritus of Biochemistry, Massachusetts Institute of Technology
Theodore Bullock, Professor of Neuroscience, University of California at San Diego
Elias Burstein, Professor Emeritus of Physics, University of Pennsylvania
Theodore L. Cairns, Professor of Chemistry
A.G.W. Cameron, Professor of Astronomy, Harvard University
Hampton Carson, Professor Emeritus of Genetics, University of Hawaii
Herbert Carter, Professor Emeritus of Chemistry, University of Arizona
Kenneth Case, Professor Emeritus, Rockefeller University
William Castle, Professor of Medicine
Michael J. Chamberlin, Professor of Biochemistry and Molecular Biology, University of California at Berkeley
Vicki Chandler, Assistant Professor of Molecular Biology, University of Oregon
S. Chandrasekhar, M.D. (Nobel Prize)
Herman Chernoff, Professor of Statistics, Harvard University
George Clark, Professor of Physics, Massachusetts Institute of Technology
Janice Clark, Institute of Molecular Biology, University of Oregon
John Clements, Professor of Biology, University of California at San Francisco
Michael D. Coe, Professor of Anthropology, Yale University
Marshall Cohen, Professor, California Institute of Technology

Mildred Cohen, Professor Emeritus of Physiological Chemistry, University of Pennsylvania
Morris Cohen, Professor Emeritus, Massachusetts Institute of Technology
Seymore Cohen, Professor Emeritus, American Cancer Society
Stanley Cohen, Professor of Biochemistry, Vanderbilt University **(Nobel Prize)**
Stanley N. Cohen, Professor of Genetics, Stanford University School of Medicine
Sidney Coleman, Professor of Physics, Harvard University
Leon Cooper, Professor of Science, Brown University **(Nobel Prize, 1972)**
Ernest Courant, Senior Physicist, Brookhaven National Laboratory
Ronald Cranford, M.D., Hennepin County Medical Center
Stanley J. Cristol, Distinguished Professor of Chemistry, University of Colorado
James Cronin, Professor of Physics, University of Chicago **(Nobel Prize, 1980)**
James Crow, Professor Emeritus of Genetics, University of Wisconsin
William J. Curran, Professor of Legal Medicine, Harvard University
Frederick Dahlquist, Professor of Chemistry, University of Oregon
James Darnell, Professor, Rockefeller University
William Daughaday, Professor, Washington University School of Medicine
Horace Davenport, Professor Emeritus of Physiology, University of Michigan Medical Center
Eric Davidson, Professor of Cell Biology, California Institute of Technology
Norman Davidson, Professor Emeritus of Chemical Biology, California Institute of Technology
Earl Davie, Professor of Biochemistry, University of Washington
Anne Davis, Professor, University of California at San Francisco School of Nursing

Bernard Davis, Professor of Bacterial Physiology, Harvard Medical School
Margaret Davis, Professor of Ecology, University of Minnesota
Nicholas Davis, Ph.D.
John Dawson, Professor of Physics, University of California at Los Angeles
Theodor Diener, Professor, University of Maryland
Frederica de Laguna, Professor Emerita, Bryn Mawr College
Susan DeRiemer, Assistant Professor of Biology, Columbia University
Edward F. Denison, Senior Fellow Emeritus, Brookings Institute
Michael Dewar, Professor of Chemistry, University of Texas
Jared Diamond, Professor of Physiology, University of California at Los Angeles Medical School
Frank Dixon, Director Emeritus, Scripps Clinic and Research Foundation
Carl Djerassi, Professor of Chemistry, Stanford University
J. Doob, Professor Emeritus
Russell Doolittle, Professor of Molecular Genetics, University of California at San Diego
Frank Drake, Professor of Astronomy/Astrophysics, University of California at Santa Cruz
Sidney Drell, Professor, Stanford University
Harry Drickamer, Professor of Chemistry, University of Illinois
Isidore Edelman, Professor of Biochemistry, Columbia University
W.T. Edmondson, Professor Emeritus of Zoology, University of Washington
John Edsall, Professor Emeritus of Biochemistry, Harvard University
Herman Eisen, Professor Emeritus of Biology, Massachusetts Institute of Technology
Judith Eisen, Assistant Professor of Biology, University of Oregon
Ernest Eliel, Professor of Chemistry, University of North Carolina
Samuel Eilenberg, Professor Emeritus, Columbia University

K.O. Emery, Senior Scientist Emeritus, Woods Hole Institute
Ellis Englesberg, Professor of Microbiology, University of California at Santa Barbara
Dorothy Erie, Institute of Molecular Biology, University of Oregon
Ronald Estabrook, Professor of Biochemistry, University of Texas
Harold Evans, Professor of Physiology, Oregon State University
Stanley Falkow, Professor of Microbiology, Stanford University
Ugo Fano, Professor Emeritus of Physics, James Frank Institute
Walter Feit, Professor of Mathematics, Yale University
Russel Fernald, Professor of Biology, University of Oregon
Herman Feshbach, Professor Emeritus, Massachusetts Institute of Technology
Gerald Fink, Professor of Genetics, Massachusetts Institute of Technology
Gerald Fischbach, Professor of Anatomy, Washington University
Janet Fleetwood, Director, Medical Humanities Program, Medical College of Pennsylvania
Robert Fletterick, Professor of Biochemistry, University of California at San Francisco
Judith Flippen-Anderson, Naval Research Lab
Henriette Foss, Institute of Molecular Biology, University of Oregon
William Fowler, Professor of Physics Emeritus, California Institute of Technology **(Nobel Prize)**
Robert T. Francoeur, Professor of Biological and Allied Health Sciences, Fairleigh Dickinson University
Ronald Freedman, Professor of Sociology Emeritus, University of Michigan
Irwin Fridovich, Professor of Biochemistry, Duke University
Josef Fried, Professor of Biochemistry, University of Chicago
Gerhart Friedlander, Professor Emeritus of Chemistry
Edwin Furshpan, Professor of Neurobiology, Harvard Medical School

Alan Garen, Professor of Microbiology, Yale University
Wendell R. Garner, Professor Emeritus of Psychology, Yale University
Marshall Gates, Professor Emeritus of Chemistry, University of Rochester
Willard Gaylin, M.D., President, The Hastings Center
Joseph Gall, Carnegie Institution of Washington
Alfred Gilman, Chair, Department of Pharmacology, University of Texas
Donald Glaser, Professor of Physics and Neurobiology, University of California at Berkeley **(Nobel Prize)**
Bentley Glass, Professor Emeritus of Biology, State University of New York
Edward Gogol, Institute of Molecular Biology, University of Oregon
Edward Goldberg, Professor of Chemistry, Scripps Institute
Gerson Goldhaber, Professor of Physics, University of California at Berkeley
Avram Goldstein, Professor Emeritus, Stanford University
Robert Gomer, Professor of Chemistry, University of Chicago
Major M. Goodman, William Neal Reynolds Professor, North Carolina State University
Victoria Gorski, Associate Director of Residency Training, Montefiore Medical Center
Verne Grant, Department of Botany, University of Texas
Jesse Greenstein, Professor of Astrophysics, California Institute of Technology
Zvi Grilches, Professor of Economics, Harvard University
David Gross, Professor of Physics, Princeton University
Jerome Gross, Biologist, Massachusetts General Hospital
Ernest Grunwald, Professor Emeritus of Chemistry
Roger Guillemin, Scientist, The Whittier Institute **(Nobel Prize, Medicine, 1977)**
Irwin C. Gunsalus, Professor of Biochemistry, University of Illinois
H.S. Gutowsky, Professor, University of Illinois
David Hagen, Institute of Molecular Biology, University of Oregon

Zach Hall, Chair, Department of Physiology, University of California at San Francisco
Harlyn Halvorson, Director, Marine Biology Lab—Woods Hole
William Harrington, Professor of Biology, Johns Hopkins University
David Harker, Research Scientist Emeritus, Medical Foundation of Buffalo
Andrew Harris, Assistant Professor of Biophysics, Johns Hopkins University
Cyril Harris, Professor Emeritus, Columbia University
Arthur Hasler, Professor of Zoology, University of Wisconsin
Robert Hauser, Professor, University of Wisconsin
Elizabeth Hay, Professor of Cellular Biology, Harvard Medical School
David S. Heeschen, Senior Scientist
D.M. Hegsted, Professor Emeritus of Nutrition
Jake Heinenmann, National Institute of Health, Rocky Mountain Lab
Ernest Henley, Professor of Physics, University of Washington
Dudley Herschbach, Professor of Chemistry, Harvard University **(Nobel Prize)**
Ernest Hilgard, Professor Emeritus of Psychology, Stanford University
Robert Hill, Department of Biochemistry, Duke Medical Center
Bertile Hille, Professor of Physiology, University of Washington
Maurice Hilleman, Physician
George Hitchings, President, Burroughs Wellcome Fund **(Nobel Laureate, 1988)**
Mahlon Hoagland, President Emeritus, Worcester Foundation for Experimental Biology
G. Hochschild, Professor Emeritus, University of California at Berkeley
Charles Hockett, Professor Emeritus, Cornell University
Joseph Hoffman, Professor of Biology, Yale School of Medicine

Roald Hoffman, Professor of Physical Science, Cornell University **(Nobel Prize)**
John Hopfield, Professor of Biology/Chemistry, California Institute of Technology
Norman Horwitz, Professor Emeritus of Biology, California Institute of Technology
James Horsfall, Director Emeritus, Connecticut Agricultural Experimental Station
Dorothy M. Horstmann, Professor Emeritus of Epidemiology, Yale University
Rollin Hotchkiss, Professor Emeritus, Rockefeller University
Louis Howard, Professor of Mathematics, University of Florida
William Howells, Professor of Anthropology Emeritus, Harvard University
Ruth Hubbard, Professor of Biology, Harvard University
David Hubel, Professor **(Nobel Prize, 1981)**
Frederick Hulse, Ph.D.
Leo Hurwich, Professor Emeritus of Psychology
Jerard Hurwitz, Sloan-Kettering Institute
Mark Inghram, Secretary, National Academy of Sciences
Erich Ippen, Professor Emeritus, Massachusetts Institute of Technology
Walter Isard, Professor of Economics
Kurt Isselbarher, Professor of Medicine, Massachusetts General Hospital
Nathan Jacobson, Professor Emeritus
Dorothea Jameson, Professor, University of Pennsylvania
Jeri Janowsky, University of Oregon
William Jencks, Professor of Biochemistry, Brandeis University
Jesse Jennings, Professor of Anthropology
Edwin Johnson, Assistant Professor, Marshall University School of Medicine
W.K. Joklik, Chair, Department of Microbology and Immunology, Duke Medical School
Irwin Kaiser, Professor, Albert Einstein College of Medicine
Arthur Kantrowitz, Professor, Dartmouth College

Jerome Karle, Chief Scientist, Naval Research Lab
(Nobel Prize)
Isabella Karle, Senior Scientist, Naval Research Lab
Joseph Keller, Professor of Mathematics,
Stanford University
David Kennedy, President, Stanford University
Eugene Kennedy, Professor of Biology/Chemistry, Harvard Medical School
H.G. Khorana, Professor of Biology/Chemistry,
Massachusetts Institute of Technology
Edwin Kilbourne, Professor, Mount Sinai School of Medicine
Daniel Kimble, Professor of Neuroscience, University of Oregon
Charles Kimmel, Professor of Biology, University of Oregon
Ivan King, Professor of Astronomy, University of California at Berkeley
Marc Kirschner, Department of Biochemistry, University of California at San Francisco
Daniel Kleppner, Professor of Physics, Massachusetts Institute of Technology
Irving Klotz, Professor of Chemistry, Northwestern University
Leon Knopoff, Professor of Physics, University of California at Los Angeles
Masakazu Konishi, Professor of Biology, California Institute of Technology
Konrad Krauskopf, Professor Emeritus of Geochemistry,
Stanford University
Edward Kravitz, Professor of Neurobiology,
Harvard Medical School
Paul E. Lacy, Professor of Pathology, Washington University Medical School
John Lacey, Professor Emeritus of Psychiatry
Willis Lamb, Professor of Physics, University of Arizona
(Nobel Prize, 1955)
Henry Lardy, Professor Emeritus, University of Wisconsin
Martin Larrabee, Professor of Biophysics, Johns Hopkins University

Alexander Leaf, Professor of Medicine, Massachusetts General Hospital
Joel Lebowitz, Professor of Physics, Rutgers University
Leon Lederman, Professor of Physics, University of Chicago
(Nobel Prize, 1988)
Erich Lehmann, Professor Emeritus, University of California at Berkeley
Estella Leopold, Professor of Botany, University of Washington
Rachmiel Levine, Director Emeritus, City of Hope Medical Center
Cyrus Levinthal, Professor of Biology
Elliot Lieb, Professor of Mathematical Physics, Princeton University
Frank Lilly, Professor of Molecular Genetics, Albert Einstein College of Medicine
Dan Lindsley, Professor Emeritus, University of California at San Diego
Richard Lindzen, Professor of Meteorology, Massachusetts Institute of Technology
Redolfo Llinas, Professor of Physiology, New York University Medical Center
Bernard Lo, M.D., Associate Professor of Medicine,
University of California at San Francisco
Franklin Long, Professor, University of California at Irvine
Lawrence Longo, Professor of Physiology, Loma Linda University
Warner Lour, Professor of Biophysics, Johns Hopkins University
Heinz Lowenstam, Professor Emeritus, California Institute of Technology
Oliver Lowry, Professor Emeritus, Washington University School of Medicine
R. Duncan Luce, Professor of Cognitive Science, University of California at Irvine
S.E. Luria, Professor Emeritus, Massachusetts Institute of Technology

James MacDonald, Professor of Physics, University of North Carolina
Sanders MacLane, Professor Emeritus of Mathematics, University of Chicago
Malcom MacNaughton, Professor of Obstetrics and Gynecology, Royal Infirmary, University of Glasgow, Scotland
Wendy K. Mariner, Associate Professor, Boston University School of Public Health
Willem Markus, Professor of Mathematics, Massachusetts Institute of Technology
Eve Marder, Assistant Professor of Biology, Brandeis University
Alan Margolis, Professor of Obstetrics and Gynecology/ Reproductive Sciences, University of California at San Francisco
Clement Markert, Professor of Animal Science, North Carolina State University
Richard Marrocco, Professor of Psychology, University of Oregon
Paul Martin, Dean of Applied Sciences Division, Harvard University
Brian Matthews, Professor of Physics, University of Oregon
Ernst Mayr, Professor Emeritus of Biology, Harvard University
Barbara McClintock, Carnegie Institution of Washington **(Nobel Prize)**
W.D. McElroy, Professor Emeritus of Biology, University of California at San Diego
Russel McIntyre, Associate Professor of Medicine, Robert Wood Johnson Medical School
Henry McKean, Director, Curant Institute of Mathematical Sciences
F.W. McLafferty, Department of Chemistry, Cornell University
Bruce Merrifield, Professor of Chemistry, Rockefeller University **(Nobel Prize)**
Valerie Merril, Postdoctoral Fellow, Brandeis University
Edwin Mertz, Professor of Biochemistry

Charles Michener, Professor Emeritus
Dimitri Miholas, Professor of Astronomy, University of Illinois
James Miller, Professor Emeritus of Oncology, University of Wisconsin
Neal Miller, Professor Emeritus, Rockefeller University
Oscar Miller, Professor of Biology, University of Virginia
Beatrice Mintz, Senior Member, Fox Chase Cancer Center
Franco Madiglioni, Professor Emeritus Economics, Massachusetts Institute of Technology **(Nobel Prize)**
Deane Montgomery, Professor Emeritus
John Moore, Professor Emeritus of Biology, University of California at Riverside
Kren Moore, Postdoctoral Fellow, University of Oregon
James Morgan, Research Scientist
Lawrence Mortin, Research Associate, Brandeis University
A.A. Moscona, Professor, University of Chicago
Arno Motulsky, Professor of Genetics/Medicine, University of Washington
W.W. Mullins, Professor
Walter Munk, Professor, University of California at San Diego
Andrew Murray, Professor of Physiology, University of California at San Francisco
Robert Murray, Chief, Division of Medical Genetics/ Department of Pediatrics, Howard University College of Medicine
Thomas Murray, Director, Center for Biomedical Ethics, Case Western Reserve University
Jack Myers, Professor Emeritus of Zoology, University of Texas
Richard Myers, Institute of Molecular Research, University of Oregon
Wendi Neckameyer, Senior Research Associate of Biology, Brandeis University
James Neel, Professor Emeritus of Genetics, University of Michigan
Oliver Nelson, Professor of Genetics, University of Wisconsin

Robert Nelson, Professor of Pediatrics/Medicine, University of California at San Francisco
Hans Neurath, Professor Emeritus of Biochemistry, University of Washington
Edward Ney, Professor
Alfred Nisonoff, Professor of Biology, Brandeis University
Masayasu Nomura, Professor of Biochemistry, University of California at Irvine
Aaron Novick, Director, Institute of Molecular Biology, University of Oregon
Peter Nowell, Department of Pathology, University of Pennsylvania
Richard Noyes, Professor of Chemistry, University of Oregon
Peter O'Day, Professor of Neuroscience, University of Oregon
Patrick O'Farrell, Professor of Biochemistry, University of California at San Francisco
Lynne Oland, Research Fellow in Neurobiology, University of Arizona
Everet Olson, Professor Emeritus of Zoology, University of California at Los Angeles
Mary Jane Osborn, Chair, Department of Microbiology, University of Connecticut Health Center
Ray Owen, Professor Emeritus of Biology, California Institute of Technology
Irwin Page, Physician
Robert Paine, Professor of Zoology, University of Washington
Alwin Pappenheimer, Professor Emeritus of Biology, Harvard University
Arthur Pardee, Professor, Harvard Medical School
Mary Lou Pardue, Professor of Biology, Massachusetts Institute of Technology
Charles Park, Professor of Physiology, Vanderbilt Medical School
Eugene Parker, Professor of Physics, University of Chicago
Robert Parr, Professor of Chemistry, University of North Carolina
Ira Pastan, Chief, Molecular Biology Lab, National Institutes of Health

Ralph Pearson, Professor Emeritus of Chemistry, University of California at Santa Barbara
David Perkins, Professor of Biology, Stanford University
Martin Perl, Professor, Stanford University
Isadore Perlman, Professor Emeritus of Chemistry, University of California at Berkeley
Robert Perry, Senior Member, Fox Chase Cancer Center
Gordon Pettengill, Director, Center for Space Research, Massachusetts Institute of Technology
Francis Pettijohn, Professor Emeritus, Johns Hopkins University
Bernard Phinney, Professor of Biology, University of California at Los Angeles
David Pines, Professor of Physics, University of Illinois
Emanuel Piore, Ph.D.
Nora Piore, Consultant, Health Services Research
Michael Posner, Professor of Psychology
Van Rensselaer Potter, Professor of Oncology Emeritus, University of Wisconsin
John Prausnitz, Professor of Chemical Engineering, University of California at Berkeley
David Prescott, Professor, University of Colorado
C. Ladd Prosser, Professor Emeritus of Physiology, University of Illinois
Edward Purcell, Professor Emeritus, Harvard University **(Nobel Prize, 1952)**
Dominick Purpura, Dean, Albert Einstein College of Medicine
Willard Quine, Professor Emeritus of Philosophy, Harvard University
Pablo Radicella, Institute of Molecular Biology, University of Oregon
Roy Radner, Professor
Thomas Raffin, Chair, Committee of Ethics, Professor of Respiratory Medicine, Stanford Medical School
Pasko Rakic, Chair of Neuroanatomy, Yale Medical School
Evelyn Ralston, Assistant Professor of Physiology, University of California at San Francisco
Norman Rasmussen, Professor

Michael Reddy, Institute of Molecular Biology, University of Oregon
Stephen Remington, Institute of Molecular Biology, University of Oregon
Roger Revelle, Professor of Science and Public Policy, University of California at San Diego
John Reynolds, Professor Emeritus of Physics, University of California at Berkeley
Stuart Rice, Dean, Division of Physical Sciences, University of Chicago
Alexander Rich, Professor, Massachusetts Institute of Technology
Frederic Richards, Professor of Molecular Biophysics, Yale University
Burton Richter, Professor of Physics, Stanford University **(Nobel Prize, 1976)**
Charles Rick, Professor/Geneticist, University of California at Davis
Lorrin Riggs, Professor of Psychology, Brown University
Frederick Robbins, Professor Emeritus **(Nobel Prize, 1954)**
Herbert Robbins, Professor Emeritus, Columbia University
Phillips Robbins, Professor of Biochemistry, Massachusetts Institute of Technology
William Roberts, Assistant Professor of Biology, University of Oregon
Phyllis Robinson, Ph.D.
Wendell Roelofs, Professor of Insect Biochemistry, Cornell University
Bernard Roizman, Professor, University of Chicago
Mark Rosenzweig, Professor of Psychology, University of California at Berkeley
John Ross, Professor of Chemistry, Stanford University
Michael Rossman, Professor of Biology, Purdue University
Mary Rothbert, Professor of Psychology, University of Oregon
Myron Rothbert, Professor of Psychology, University of Oregon
Irving Rouse, Professor Emeritus of Anthropology, Yale University
Vera Rubin, Physician, Carnegie Institution of Washington

Joan Rutila, Postdoctoral Fellow in Biology, Brandeis University
William Rutter, Chair, Chiron Corporation
Robert Sachs, Professor Emeritus of Physics, University of Chicago
Paul Samuelson, Professor Emeritus of Economics, Massachusetts Institute of Technology **(Nobel Prize, 1970)**
Ruth Sager, Professor, Harvard Medical School
Brian Sanders, Chairperson, Ethics Committee
Charles Sawyer, Professor Emeritus of Anatomy, University of California at Los Angeles Medical School
Howard Schachman, Professor of Molecular/Cell Biology, University of California at Berkeley
Berta Scharrer, Professor Emeritus, Albert Einstein Medical School
Thomas Schelling, Professor of Political Economy
F. Charlotte Schellman, Institute of Molecular Biology, University of Oregon
John Schellman, Professor of Chemistry, University of Oregon
H.A. Scheraga, Professor of Chemistry, Cornell University
Patricia Schimke, Research Associate, Boston University Medical Center
Robert Schimke, Professor of Biology, Stanford University
Knut Schmidt-Nielsen, Professor of Zoology, Duke University
Francisco Schmitt, Professor, Massachusetts Institute of Technology
David Schramm, Professor, University of Chicago
Jaco Schwartz, Professor of Math/Computer Science, Courant Institute
Ernest Sears, Professor Emeritus, University of Missouri
William Sears, Professor Emeritus, University of Arizona
Irving Segal, Professor, Massachusetts Institute of Technology
Steven Selfried, Research Fellow, University of Oregon
Eric Selker, Assistant Professor of Biology, University of Oregon

James Serrin, Professor of Mathematics, University of Minnesota
Philip Sharp, Professor
Robert Sharp, Professor Emeritus of Geology, California Institute of Technology
Aaron Shatkin, Scientist
Roger Shepard, Professor of Psychology, Stanford University
William Sheridan, Professor of Biology, University of North Dakota
Eugene Shoemaker
Robert Shulman, Professor of Biochemistry, Yale University
Philip Siekevitz, Professor Emeritus, Rockefeller University
Leon Silver, Professor of Geology, California Institute of Technology
Maxine Singer, President, Carnegie Institution of Washington
Jonathan Singer, Professor of Biology, University of California at San Diego
Philip Skell, Professor
G. William Skinner, Professor of Anthropology, Stanford University
Folke Skoog, Professor Emeritus of Botany, University of Wisconsin
David Slepian
Joseph Smith, Professor
George Snell, Senior Scientist Emeritus **(Nobel Prize, 1980, Medicine)**
Solomon Snyder, Professor of Neuroscience/Pharmacology/Psychiatry, Johns Hopkins University
Richard Solomon
Roger Sperry, Board of Trustees, Professor Emeritus, California Institute of Technology **(Nobel Prize, Medicine)**
F. Spitzer, Professor of Mathematics, Cornell University
George Sprague, Institute of Molecular Biology, University of Oregon
James Sprague, Professor Emeritus of Anatomy, University of Pennsylvania
Karen Sprague, Institute of Molecular Biology, University of Oregon

Earl Stadtman, Chief, Lab of Biochemistry, National Institutes of Health
Thressa Stadtman, Biochemistry Lab, National Institutes of Health
Franklin Stahl, Institute of Molecular Biology, University of Oregon
Daniel Steinberg, Professor of Medicine, University of California at San Diego
Robert Steinberg, Professor of Mathematics, University of California at Los Angeles
Donald Steiner, Senior Investigator, Howard Hughes Medical Institute
Joan Steitz, Department of Biochemistry/Biophysics, Yale University
Eliot Stellar, Professor, University of Pennsylvania Medical School
Tom Stevens, Institute of Molecular Biology, University of Oregon
Richard Stewart, Institute of Molecular Biology, University of Oregon
Elizabeth Stine, Professor of Psychology, Brandeis University
Michael Strain, Institute of Molecular Biology, University of Oregon
Paul Stumph, Professor of Biochemistry/Biophysics, University of California at Davis
Julian Sturtevant, Professor of Chemistry Emeritus, Yale University
Hewson Swift, Professor of Molecular Genetics/Cell Biology, University of Chicago
Lynn Sykes, Professor of Geology, Columbia University
Terry Takahshi, Professor of Biology, University of Oregon
David Talmage, Professor of Medicine, University of Colorado
Champ Tanner, Professor Emeritus, University of Wisconsin
C. Richard Taylor, Professor of Biology, Director, Concord Field Station
Philip Teitelbaum, Professor of Psychology, University of Florida
Kenneth Thimann, Professor Emeritus of Biology
E. Donnell Thomas

Ignacio Tinoco, Professor of Chemistry, University of California at Berkeley
Leslie Tolbert, Assistant Professor of Neurobiology, University of Arizona
William Trager, Professor Emeritus, Rockefeller University
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Harold Varmus, Professor of Molecular Virology, University of California at San Francisco
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APPENDIX E

AD HOC COMMITTEE OF STATE LEGISLATORS

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Marlin Appelwick, Representative, State of Washington
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Rosalyn Baker, Representative, State of Hawaii
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Judith C. Bauman, Representative, State of Oregon
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Patricia H. Billings, Delegate, State of Maryland
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Jan Brown, Representative, State of Montana
Kay Brown, Representative, State of Alaska
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Mark Boyer, Representative, State of Alaska
Stephanie Bush, Assemblywoman, State of New Jersey
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Mike Kadas, Representative, State of Montana
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Harriet Keyserling, Representative, State of South Carolina
Richard King, Representative, State of Washington
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Niilo Koponen, Representative, State of Alaska
Nancy Kopp, Representative, State of Maryland
Richard Kraus, Senator, Commonwealth of Massachusetts
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Samuel Lee, Representative, State of Hawaii
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Jay Levin, Representative, State of Connecticut
Vi Luginbuhl, Representative, State of Vermont
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Bennet Mazur, Assemblyman, State of New Jersey
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Susan McLane, Senator, State of New Hampshire
Pauline Menes, Delegate, State of Maryland
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Ray Moore, Senator, State of Washington
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Dick Nelson, Representative, State of Washington
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Larry Phillips, Representative, State of Washington
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Mark Roosevelt, Representative, Commonwealth of Massachusetts
Ralph Rosenberg, Representative, State of Iowa

Ida Ruben, Senator, State of Maryland
Nancy Rust, Representative, State of Washington
Thomas Rutherford, Senator, State of New Mexico
Helen Satterthwaite, Representative, State of Illinois
Susan Schur, Representative, Commonwealth of Massachusetts
Sue Shear, Representative, State of Montana
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Ada Smith, Senator, State of New York
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Lynn Taborsak, Representative, State of Connecticut
Jane Teaford, Representative, State of Iowa
David Thorp, Representative, State of Connecticut
Bennet Truman, Representative, State of Vermont
Fran Ulmer, Representative, State of Arkansas
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Art Wang, Representative, State of Washington
Maxine Waters, Assemblywoman, State of California
Eleanor Weinstock, Senator, State of Florida
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Lawrence Wiser, Delegate, State of Maryland
Lorraine Wojahn, Senator, State of Washington
Gregory Young, Assemblyman, State of New York
Rebecca Young, Representative, State of Wisconsin
Mark Youngdahl, Representative, State of Maryland

AMICUS CURIAE

BRIEF

Supreme Court, U.S.
FILED
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JOSEPH F. SPANIOL, JR.
CLERK

Nos. 88-790, 88-1309

IN THE

Supreme Court of the United States

OCTOBER TERM 1989

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v.

RICHARD M. RAGSDALE, et al., *Appellees*.

On Appeal from the United States Court of Appeals for the Seventh Circuit

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v.

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QUESTION PRESENTED HEREIN

Whether stare decisis, in light of the standards announced in *Patterson v. McLean Credit Union*, prevents reconsideration of *Roe v. Wade*?

TABLE OF CONTENTS

	Page:
Question Presented Herein	i
Table of Contents	ii
Table of Authorities	iii
Interest of Amici	2
Summary of Argument	2
Argument	3
I. The Stare Decisis Standards for Reconsideration of Precedent Announced in *Patterson* are fully Met	3
A. *Roe v. Wade* has been Undermined by Subsequent Changes and Development in the Law	5
1. *Roe* has been Undermined by *Webster v. Reproductive Health Services*	6
2. *Roe* has been Undermined by *Michael H. v. Gerald D.* and *Bowers v. Hardwick*	11
B. *Roe v. Wade* is a Positive Detriment to Coherence and Consistency in the Law	13
1. *Roe v. Wade* is an Unworkable Decision which has Created Inherent Confusion in the Law	13
2. *Roe v. Wade* Poses a Direct Obstacle to the Realization of Important Objectives Embodied in other Laws	16
C. *Roe v. Wade* is Outdated and is Inconsistent With the Sense of Justice and the Social Welfare	20
II. *Roe v. Wade* Should be Reversed	27

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BRIEF AMICI CURIAE OF THE HON. CHRISTOPHER H. SMITH, ALAN B. MOLLOHAN, VIN WEBER, ROBERT K. DORNAN, EARL HUTTO, JOHN J. LaFALCE, VIRGINIA SMITH, BILL EMERSON, HENRY J. HYDE AND GORDON J. HUMPHREY MEMBERS OF THE CONGRESS OF THE UNITED STATES, IN SUPPORT OF APPELLANTS IN TURNOCK AND CROSS-PETITIONERS IN HODGSON

INTEREST OF AMICI[1]

The amici are members of the Congress of the United States. Representatives Christopher H. Smith and Alan B. Mollohan are Co-Chairmen of the Congressional Pro-Life Caucus, an organization of congresspersons who oppose abortion on demand. Representatives Vin Weber and Virginia Smith are members of the United States House of Representatives Appropriations Committee which has jurisdiction over the appropriation of federal funds for the provision of abortion services. Representatives Robert K. Dornan, Earl Hutto, John J. LaFalce, Bill Emerson, and Henry J. Hyde are members of the Congressional Pro-Life Caucus. Senator Gordon J. Humphrey is a member of the Senate Judiciary Committee and the Senate Pro-Life Action Task Force for Women, Children and the Unborn. All support the reconsideration and reversal of *Roe v. Wade* by this Court.

SUMMARY OF ARGUMENT

In *Patterson v. McLean Credit Union*, this Court set out three standards, any one of which, if met, deprive a precedent of stare decisis respect. Your amici argue that *Roe v. Wade* meets all three tests. First, *Roe v. Wade* has been undermined by subsequent changes and development in the law. *Roe* been systematically undermined by its progeny which depart from the limitations expressed in *Roe*. Further, *Webster v. Reproductive Health Services* heralded a new willingness to uphold state laws protective of unborn human life in contrast to the previous extreme hostility to any meaningful regulation of abortion. The decision also demonstrated the disappearance of majority support for the trimester scheme set up in *Roe*, and a change in the standard of review for abortion regulations.

Second, *Roe v. Wade* is a positive detriment to coherence and consistency in the law. *Roe* is an unworkable decision which has

[1] This Brief Amici Curiae is filed with the consent of all parties to this appeal. A letter from each attorney stating this consent has been filed with the Clerk of this Court.

created inherent confusion in the law because of the use of the trimester medical criteria. It also poses a direct obstacle to the realization of important objectives embodied in other laws in relation to the rights of the unborn in tort law, in wrongful death actions, in equity, in criminal law, and in laws relating to respect.

Third, *Roe v. Wade* is outdated and should be found to be inconsistent with the sense of justice and the social welfare. Examples of this inconsistency include: the rejection of *Roe* in scholarly analysis and political activity; the use of *Roe*, in practice and in law, to justify discrimination against the unborn in general, and those with disabilities in particular; the practice of sex selection abortions; the developments in medicine whereby the fetus is treated as a patient; public opinion in opposition to abortion on demand; and abortion as the exception which swallows all commonly accepted rules of law.

ARGUMENT

I. THE STARE DECISIS STANDARDS FOR RECONSIDERATION OF PRECEDENT ANNOUNCED IN *PATTERSON* ARE FULLY MET.

Stare decisis is usually the wise policy, because in most matters it is more important that the applicable rule of law be settled than it be settled right. This is commonly true even where the error is a matter of serious concern, provided correction can be had by legislation. But in cases involving the Federal Constitution where correction through leglislative action is practically impossible, this Court has often overruled its prior decisions. The Court bows to the lessons of experience and the force of better reasoning, recognizing that the process of trial and error, so fuitful in the sciences, is appropriate also in the judicial function.

Burnet v. Coronado Oil & Gas Co., 285 U.S. 393, 406-410 (1932) (Brandeis, J., dissenting).[2] On almost 90 occassions since *Burnet*, this Court has reviewed and reversed its decisions on constitutional law. Maltz, *Some Thoughts on the Death of Stare Decisis in Constitutional Law*, 1980 Wis. L. Rev. 467, 494-496 (listing 47 constitutional decisions overturned 1960-1979); Blaustein & Field, *"Overruling" Opinions in the Supreme Court*, 57 Mich. L. Rev. 151, 167, 184-194 (1958) (identifying 60 constitutional law decisions among 90 overrulings of prior Supreme Court decisions). The Library of Congress has identified, through 1986, 184 cases in which this Court has reversed its own prior rulings. Congressional Research Service, *The Constitution of the United States, Analysis and Interpretation*, 2115-2127, & Supp. (1987).

Given the importance of stare decisis in the law, it is appropriate that this Court set forth a reliable standard for determining when reconsideration is proper. This was done most recently in *Patterson v. McLean Credit Union*, 109 S.Ct. 2363 (1989), which stated:

> Our precedents are not sacrosanct, for we have overruled prior decisions where the necessity and propriety of doing so has been established. Nonetheless, we have held that "any departure from the doctrine of *stare decisis* demands special justification." We have also said that the burden borne by the party advocating the abandonment of an established precedent is greater where the Court is asked to overrule a point of statutory constuction. Considerations of *stare decisis* have special force in the area of statutory interpretation, for here, *unlike in the context of constitutional interpretation*, the legislative power is implicated, and Congress remains free to alter what we have done.

[2] Justice Brandeis identified 28 instances in which the Court had reversed or qualified its own prior reading of the Constitution. That number has at least tripled in the years since *Burnet*. *See* Maltz, *Some Thoughts on the Death of Stare Decisis in Constitutional Law*, 1980 Wis. L. Rev. 467, 467.

Id. at 2370 (emphasis added). Thus, unlike *Patterson*, reconsideration of *Roe v. Wade*, 410 U.S. 113 (1973), involves constitutional interpretation rather than statutory interpretation. The burden borne in establishing the necessity of reconsideration is therefore diminished.

In *Patterson*, this Court set out three standards, any one of which, if met, constitutes sufficient justification to reconsider a judicial precedent. Your amici argue that *Roe v. Wade* meets all three tests and is thus ripe for reconsideration.

The *Patterson* standards are: (1) Whether the precedent has been "undermined by subsequent changes or development in the law;" (2) Whether the precedent is "a positive detriment to coherence and consistency in the law, either because of inherent confusion created by an unworkable decision," or "because the decision poses a direct obstacle to the realization of important objectives embodied in other laws;" or (3) Whether the precedent is "outdated and after being 'tested by experience, has been found to be inconsistent with the sense of justice or with the social welfare.'" *Patterson*, 109 S.Ct. at 2371 (citations omitted). Each of these tests will be applied to *Roe v. Wade* below.

A. *ROE V. WADE* HAS BEEN UNDERMINED BY SUBSEQUENT CHANGES AND DEVELOPMENT IN THE LAW.

Contributing to the undermining of *Roe* is the fact that, while claiming to follow *Roe*, this Court has systematically gutted *Roe* in order to provide for the desired result. *See, e.g., Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 783 (1986) (Burger, C. J., dissenting) ("The extent to which the Court has departed from the limitations expressed in *Roe* is readily apparent."). The doctrine of stare decisis presupposes a precedent with content to be followed. By emptying *Roe* of content, the Court's appeal to stare decisis is now an appeal only to the skeletal concept that a woman may have an abortion whenever she desires, for whatever reason.

However, the undermining of *Roe* in *Roe's* progeny takes a secondary place to the important changes heralded by the decisions in *Webster v. Reproductive Health Services*, 109 S.Ct. 3040 (1989), *Michael H. v. Gerald D.*, 109 S.Ct. 2333 (1989), and *Bowers v. Hardwick*, 106 S.Ct. 2841 (1986).

1. *ROE* HAS BEEN UNDERMINED BY *WEBSTER V. REPRODUCTIVE HEALTH SERVICES.*

The most profound change in abortion jurisprudence came when this Court decided *Webster*. Supreme Court Justice Oliver Wendell Holmes, Jr. declared that the state of the law is nothing more than a prediction of what the courts will do. Holmes, *The Path of the Law*, 10 Harv. L. Rev. 457 (1897). This is an insight impressed upon modern jurisprudence by the philosophical school of legal realism. Employing this analysis, one may readily determine the state of abortion law by examining the opinions of members of the new *Webster* majority in prior abortion cases and in *Webster*. The evidence indicates that a significant, de facto alteration has occurred in the state of abortion law. Several aspects of *Webster* undermine *Roe* and its progeny.

First, the alteration of abortion jurisprudence is apparent in the fact that the challenged provisions of the Missouri abortion law were all upheld. The provisions had all been declared unconstitutional by the Eighth Circuit Court of Appeals and would have been declared unconstitutional by the four member dissent in *Webster*. 109 S.Ct. at 3068 n.1 (Blackmun, J., dissenting).

This willingness to uphold life-protective laws is a dramatic change from this Court's prior pattern of striking down virtually every meaningful regulation of abortion. This new willingness to uphold state efforts to protect unborn human life signals a *sub silentio* reversal of the extreme results and hostility to virtually any abortion regulation which were evident in the Court's most recent abortion decisions, *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983), and

Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747 (1986).

Second, the alteration of abortion jurisprudence is evident in the disappearance of majority support for the trimester scheme set up in *Roe*. This decision results in a de facto reversal of that scheme, along with its viability line for protection of unborn life. Justice O'Connor declared her belief that a state has a compelling interest in unborn life and maternal health throughout pregnancy in her earlier dissents to *Akron* and *Thornburgh*. *Thornburgh*, 476 U.S. at 828 (O'Connor, J., dissenting)("I . . . remain of the views I expressed in my dissent in *Akron*. The State has compelling intersts in ensuring maternal health and in protecting potential human life . . . throughout pregnancy."). With Justices Rehnquist, White, Scalia and Kennedy declaring the same view in *Webster*,[3] five justices have now recognized that a state's interest in protecting unborn human life does not become compelling *only* after viability, but exists throughout pregnancy. Likewise, the line between first and second trimesters, where *Roe* said the states' interest in maternal health becomes compelling, is now meaningless.

Third, the de facto shift in abortion jurisprudence may be seen in Justice O'Connor's argument that the Missouri viability testing requirement was compatible with *Akron* because it did not "unduly burden" a woman's right to abortion. *Webster*, 109 S.Ct. at 3062-64. This unduly burdensome or "absolute obstacle" test, which she championed in *Akron* and under which she felt the *Akron* ordinances could be upheld, was rejected by the *Akron* majority which struck down the *Akron* ordinances she approved. *Akron*, 462 U.S. 420 n.1. With four other justices now willing to go even further in *Webster* than was Justice O'Connor, it is clear that the absolute obstacle test now is the resulting standard among the majority. Thus, for the time

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[3] Justice Scalia would reverse *Roe* outright in *Webster*, holding that there is no fundamental constitutional right to abortion. However, if such a right is maintained, it is assumed he would agree that the state has countervailing compelling interests.

being, it will be the de facto standard of review for abortion statutes. A review of Justice O'Connor's *Akron* and *Thornburgh* dissenting opinions reveals that many state regulations of abortion will pass muster under her analysis.[4]

At present, four justices of the new majority will scrutinize abortion statutes using a rational basis test, the Court's lowest level of scrutiny. Justice O'Connor has no problem with this standard of review, except in the cases where the legislation is an absolute obstacle or a "severe limitation" to obtaining an abortion. While the scope of this test is not yet fully fleshed out, the practical result is that *Roe* has been substantially modified and much legislation to protect unborn life will be permitted.

Fourth, another aspect of the de facto shift in abortion jurisprudence is closely related to the previous one. It involves the nature of the woman's interest in abortion itself, which governs the standard of review. Under the usual analysis, if one has a "fundamental right," the state must show a "compelling interest" to regulate it. That standard is almost impossible to meet, making regulation of fundamental rights virtually

[4] In *Thornburgh*, Justice O'Connor stated her absolute obstacle analysis as follows:

> I . . . remain of the views expressed in my dissent in Akron. The State has compelling interests in ensuring maternal health and in protecting potential human life, and these interests exist throughout pregnancy. Under this Court's fundamental-rights jurisprudence, judicial scrutiny of state regulation of abortion should be limited to whether the state law bears a rational relationship to legitimate purposes such as the advancement of these compelling interests, with heightened scrutiny reserved for instances in which the State has imposed an undue burden on the abortion decision. An undue burden will generally be found in situations involving absolute obstacles or severe limitations on the abortion decision, not wherever a state regulation may inhibit abortion to some degree. And if a state law does interfere with the abortion decision to an extent that is unduly burdensome, so that it becomes necessary to apply an exacting standard of review, the possibility remains that the statute will withstand the stricter scrutiny. *Thornburgh*, 476 U.S. at 828 (O'Connor, J., dissenting, joined by Rehnquist, J., in her opinion)(internal quotation marks and citations omitted.).

impossible for the state to do. However, if one only has a "liberty interest," a state need only demonstrate a "rational basis" for its regulations — a much simpler task, allowing states to extensively regulate it.

The *Webster* plurality declared that a woman has only a liberty interest in abortion under the Fourteenth Amendment, not a fundamental right to abortion as *Roe* held. *Webster*, 109 S.Ct. at 3058. Justice Scalia concurs that there is no fundamental right to abortion. *Id.* at 3064-67. Justice O'Connor, by her advocacy of the rational basis standard of review in most cases, concurs, as well, that there is no general fundamental right to abortion. *Akron*, 462 U.S. at 453 (O'Connor, J., dissenting). However, where there is an undue burden, she might find a fundamental right (for she would employ the compelling interest standard in such cases). She made an assumption, *arguendo*, in *Akron*, where she said, "Even *assuming* that there is a fundamental right to terminate pregnancy *in some situations*, there is no justification in law or logic for the trimester framework . . . ." *Id.* at 459 (emphasis added).

Thus, five justices now agree that, at a minimum, there is no *general* fundamental right to abortion; in most cases, there is only a liberty interest. Four would hold that there is no fundamental right to abortion in any situation. Of course, as noted above, five justices now find that states have the compelling interests — in both unborn life and maternal life — necessary to allow states to regulate abortion.

Fifth, another aspect of the de facto shift in abortion jurisprudence exists with regard to the "narrowly tailored" test in *Roe*. The *Roe* Court indicated that to regulate a woman's fundamental right to abortion a state must show (1) that it has a compelling interest in doing so and (2) that any such regulation is narrowly tailored to effect only that compelling interest. *Roe*, 410 U.S. at 155. Thus, the standard of review for state regulations impinging upon the declared fundamental right to abortion has been widely thought to consist of these two prongs. But Justice O'Connor wrote in *Akron*:

> The Court has never required that state regulation that burdens the abortion decision be 'narrowly tailored' to express only the relevant state interest. In Roe, the Court mentioned 'narrowly drawn' legislative enactments, but the Court never actually adopted this standard in the Roe analysis. In its decision today, the Court fully endorsed the Roe requirement that a burdensome health regulation, or as the Court appears to call it, a 'significant obstacle" be 'reasonably related' to the state compelling interest. The Court recognizes that '[a] state necessarily must have latitude in adopting regulations of general applicability in this sensitive area.'

Akron, 462 U.S. at 467 n.11 (O'Connor, J., dissenting)(citations omitted, case names not italicized in original).

This "reasonably related" test is significantly easier for a state to meet than the "narrowly tailored" test, as Justice O'Connor proceeded to demonstrate in *Akron*. *Id.* With her fellow Justices in the *Webster* majority prepared to go farther, this reasonably related test is now the de facto second prong in the new standard for reviewing abortion laws which will come before the Court.

The practical result of all these changes is that — at a minimum — *Akron* and *Thornburgh* are now dead letters. Things declared unconstitutional in those cases — which Justice O'Connor declared constitutional under her analysis (such as informed consent requirements) — may now be found constitutional.

That the new alliance on the Court portends great changes in *Roe* seems clear enough to the *Webster* dissenters. Justice Blackmun, after reading his opponents' opinions and counting the votes in *Webster*, says he fears for the future. He observed the danger in which *Roe* has been placed:

> It is impossible to read the plurality opinion and especially its final paragraph, without recognizing its implicit invitation to every State to enact more and more restrictive abortion laws, and to assert their interest in potential life as of the moment of conception. All these laws will satisfy the plurality's non-scrutiny, until sometime, a new regime of old dissenters and new appointees will declare what the plurality intends: that *Roe* is no longer good law.

Webster, 109 S.Ct. at 3077.

The chief flaw in Justice Blackmun's *Webster* analysis is that *Roe's* demise is not prospective only. In *Webster*, a de facto reconsideration and partial reversal of that ill-fated decision has already occurred.

2. *ROE* HAS BEEN UNDERMINED BY *MICHAEL H. V. GERALD D.* AND *BOWERS V. HARDWICK*.

The Court has recently clarified the fundamental rights analysis and this clarification undermines the fundamental rights analysis in *Roe*. In *Bowers v. Hardwick*, 106 S.Ct. 2841 (1986), the Court, examining the history of state regulation of sodomy, concluded that there was no fundamental right to commit sodomy. Yet, the historical case for the fundamentality of abortion is no more convincing than the historical case for sodomy. The *Roe* majority cited Plato's *Republic* as evidence of abortion's deep roots in our cultural traditions. 410 U.S. at 131. The *Bowers* majority apparently did not deem this sort of evidence as worthwhile. 478 U.S. at 193-94 (no mention whatsoever of instances in ancient texts where the practice of homosexuality is condoned). Plato's dialogues contain numerous allusions to the practice of homosexual sodomy among the ancients. *See* Plato, *Phaedrus;* Bopp & Coleson, *The Right to Abortion: Anomalous, Absolute, and Ripe for Reversal*, 3 B.Y.U. J. Public Law 180, 240 (1989).

The test used in *Bowers* was a historical one, that is, whether such conduct is "deeply rooted in this Nation's history and tradition." 106 S.Ct. at 2844 (quoting *Moore v. East Cleveland*, 431 U.S. 494, 503 (1977) (Powell, J., concurring)). Finding that homosexual sodomy had long been regulated by the states, the

Court concluded that it did not constitute a fundamental right. *Id.* at 2844-46.

A more recent case is *Michael H. v. Gerald D.*, 109 S.Ct. 2333 (1989). In it the Court considered whether a biological father (who is adulterous) has a constitutional right to visit his child born in an intact marriage. Using the historical test of *Bowers*, the Court held that there is no fundamental right to visitation in such a case, because states have historically presumed that a child born within a marriage is the product of that marriage and rejected visitation claims by adulterous fathers.

Under the historical analysis test for determining whether proposed rights are fundamental, endorsed by the five justices who have expressed opposition to *Roe*, a fundamental right to abortion cannot be found in the United States Constitution. This is true even though more than half of the majority opinion in *Roe* was given to the history of abortion. The majority in *Roe* relied heavily, and uncritically, on the work of Professor Cyril Means. 410 U.S. at 132-39.[5] Means' history of abortion was neither objective nor accurate.[6]

Had this historical test for fundamentality been scrupulously applied in *Roe*, no right to abortion could have been found. This being true, *Roe* should be revisited.

Roe has been undermined by subsequent changes and development in the law. Ironically, this is true both in those decisions which expand the abortion right beyond *Roe*, and in the decision in *Webster* which permits the states to restrict that right. Thus, *Roe* should be reconsidered.

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[5] The majority cited Means seven times during its depiction of the history of abortion — without noting that he was the general counsel of the National Association for the Reform of Abortion Laws (now the National Abortion Rights Action League).

[6] *See* Brief of the American Academy of Medical Ethics, as *Amicus Curiae*, filed herein.

B. *ROE V. WADE* IS A POSITIVE DETRIMENT TO COHERENCE AND CONSISTENCY IN THE LAW.

The second test enunciated in *Patterson* is whether a precedent is a "positive detriment to coherence and consistency in the law." 109 S.Ct. at 2371. This test has two possible grounds: (1) inherent confusion is "created by an unworkable decision", or (2) the decision "poses a direct obstacle to the realization of important objectives embodied in other laws." *Id.*

1. *ROE V. WADE* IS AN UNWORKABLE DECISION WHICH HAS CREATED INHERENT CONFUSION IN THE LAW.

Roe v. Wade was intended to settle the issue of abortion in American law. However, *Roe* has proven to be inherently difficult to apply in any consistent and principled manner. This fact is evident in *Roe's* progeny, which have produced a growing body of intricate and arbitrary, judicially-created regulations surrounding the abortion decision. For example, a state may require second trimester abortions to be performed in clinics, *Simopolous v. Virginia*, 462 U.S. 506 (1983), but may not require that they be performed in hospitals, *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 459 (1983). A state may require a physician to assure that certain information be provided to a pregnant woman, *Akron*, 462 U.S. at 448, but may not require that the doctor himself provide the information. *Id.* at 449. The quantum of information a state may require to be provided has been severely circumscribed. *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 759, 765 (1986). Prior to the decision in *Webster*, this Court struck down any meaningful attempt to codify the restrictions allowed in *Roe* and abandoned key elements of the *Roe* formula when convenient. Far from settling the debate, these subsequent decisions have multiplied confusion and spawned further unanswered questions.

It is clear, then, that, while the pro-*Roe* majority has raised the cry of stare decisis in prior cases upholding *Roe*, it has not followed its own precedent, except in the most skeletal fashion.

Illustrations abound in prior cases and include, but are not limited to, the following important developments: (1) The erosion of *Roe's* "bright line" trimester analysis; and (2) The ignoring of the physican consultation requirements. *Gary-Northwest Ind. Women's Serv. v. Orr*, 451 U.S. 934 (1981); *Akron*, 462 U.S. at 448.[7]

The inherent confusion in the law as a result of *Roe* can be illustrated in reference to four considerations: the trimester medical criteria, physician discretion, informed consent, and records. The medical criteria employed in the *Roe* trimester scheme were faulty and inadequate as a basis for a constitutional right. The unfettered discretion and deference afforded physicians in the abortion context is anomalous in light of the extensive regulation of medical practice. *See* Bopp & Coleson, *supra*, at 285. The treatment of the informed consent doctrine in the abortion context is out of step with the current trend of the law and regresses to a widely rejected model of the physician-patient relationship. *Id.* at 291. Even reasonable recording and reporting requirements have been struck down. *Id.* at 297.

The Court in *Roe* decided that the state could not regulate abortion in the first trimester, as abortion was considered safer than continuing the pregnancy during that period. *Roe*, 410 U.S. at 149, 163. In reaching this conclusion, Justice Blackmun referred to medical data from the appellant and amicus briefs.[8] The studies cited supported the proposition that abortion was safer during this period. 410 U.S. at 149. However, a review of opposing amicus briefs reveals contradictory data ignored by the Court. *See* Brief for Certain Physicians, Professors and

[7] For a more complete discussion and further illustrations of stare decisis abuse, *see* Bopp & Coleson, *The Right to Abortion: Anomalous, Absolute, and Ripe for Reversal*, 3 B.Y.U. J. Public Law 180, 201-10 (1989).

[8] *Id.* at 330. The Court's trimester scheme should not be confused with the medical division of pregnancy into three three-month periods. *See* Wolfe v. Schroering, 388 F. Supp. 631, 635 (W.D. Ky. 1974), *aff'd*, 541 F.2d 523 (6th Cir. 1976); Special Project, *Survey of Abortion Law*, 1980 Ariz. St. L.J. 67, 139-42.

Fellows of the American College of Obstetrics and Gynecology at 33-50, *Roe v. Wade*, 410 U.S. 113 (1973); Brief for Robert L. Sassone at 25-36, *Roe v. Wade*, 410 U.S. 113 (1973). The Court gave undue deference to certain segments of the medical community over others. Moreover, the asserted facts were in reality only opinions of certain medical groups. *See* Bopp & Coleson, *supra*, at 283-84. Subsequent articles and studies have supported the argument that the *Roe* Court's medical fact was really ill-founded medical opinion.[9] The *Roe* Court's exteme deference to such opinions, and to what were basically legislative facts, was unwarranted. With this foundation removed, the first trimester rule is without basis. Moreover, as medical technology changes, the relative safety of abortion and childbirth will remain a mobile guideline.

The *Roe* Court also relied on medical factors in drawing the line between the second and third trimesters, which was placed at viability. At viability, the state's interest in fetal life was to become compelling. *Roe*, 410 U.S. at 160. However, determining viability is a difficult task, leaving legislatures with an almost insurmountable task in asserting their declared compelling interest in fetal life and doctors in the precarious position of having possible criminal penalties flow from an erroneous judgment of nonviability. The result has been more litigation, resulting in a wide berth being required of legislatures when legislating around the point of viability, and virtually unchallenged discretion being allowed physicians in

[9] *See* Hilgers & O'Hare, *Abortion Related Maternal Mortality: An In-Depth Analysis*, in *New Perspectives on Human Abortion* 69-91 (T. Hilgers, D. Horan & D. Mall eds. 1981) (application of more accurate formulas produced a finding that natural pregnancy is safer than legal abortion in both the first and second twenty weeks of pregnancy). *See also* Destro, *Abortion and the Constitution: The Need for a Life-Protective Amendment*, 63 Calif. L. Rev. 1250, 1295-1303 (1975).

making the determination of viability.[10] As with the line between the first and second trimesters, the viability line is a function of advances in medical technology. This fact renders *Roe* an unworkable decision creating inherent confusion in the law.

2. *ROE V. WADE* POSES A DIRECT OBSTACLE TO THE REALIZATION OF IMPORTANT OBJECTIVES EMBODIED IN OTHER LAWS.

Roe v. Wade poses a direct obstacle to the realization of important objectives embodied in other laws which recognize and protect unborn human life. If *Roe* were taken seriously in these other contexts, no recognition or protection of unborn human life would be possible. However, where the abortion choice is not in issue, the courts have rejected the *Roe* rationale. Examples include the rights of the unborn in tort law, wrongful death actions,[11] in equity,[12] in criminal law[13] and in laws relating to respect.[14]

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[10] *See Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 63-65 (1976). *Danforth* stressed the flexibility of the *Roe* viability concept in upholding abortion legislation. *Id.* at 65. In *Colautti v. Franklin*, 439 U.S. 379 (1979), the Court struck down a state statute very similar to *Danforth's*. The fatal flaw was vagueness. *Id.* at 393. It is ironic that attempts to make the viability concept more definite have been struck down as too restrictive, while the formula, or very similar ones, used by the Court are inherently vague. The result is that little protection of the compelling state interest in fetal life is extant. The testimony in *Danforth* produced a wide range of definitions of viability. *Id.* at 396 n.15. See generally, Note, *Current Technology Affecting Supreme Court Abortion Jurisprudence*, 27 N.Y.L. Sch. L. Rev. 1221 (1982).

[11] Bopp & Coleson, supra note 7, at 250.

[12] Id. at 261.

[13] Id. at 268.

[14] Id. at 281.

The most dramatic illustration of the anomalies of abortion jurisprudence can be seen in the evolution of fetal rights in tort law in the past ninety years. The rights of the unborn child have moved from a position of little legal protection to a position where even preconception wrongs are recompensible. As duties to the fetus increase, the foundation upon which *Roe* sits erodes, turning it into the exception rather than the rule in defining the personhood of the fetus.

The first American case which dealt with fetal injury was the celebrated opinion by Judge Oliver Wendell Holmes, Jr. in *Dietrich v. Northampton*, 138 Mass. 14 (1884). Holmes interpreted the Massachusetts wrongful death act to preclude recovery for the death of a four to five month old fetus.[15] He held that "the unborn child was a part of the mother at the time of injury" and that "any damage to [the fetus] which was not too remote to be recovered for at all was recoverable by her." *Id.* at 17.

Dietrich was followed until 1946, when, in the words of William Prosser, "the most spectacular [and] abrupt reversal of a well settled rule in the whole history of the law of torts" occurred. W. Prosser, *Handbook on the Law of Torts* 336 (4th ed. 1971). In *Bonbrest v. Kotz*, 65 F.Supp. 138 (D.D.C. 1946), a federal court allowed the plaintiff infant to recover for injuries sustained when he was negligently taken, as a viable fetus, from his mother's womb by the defendant doctor. *Id.* at 143. The reasoning in *Bonbrest* stated:

> As to the viable child being 'part' of its mother — this argument seems to me to be a contradiction in terms. True, it is in the womb, but it is capable now of extra-uterine life — and while dependent for its continued development on sustenance derived from its peculiar relationship to its mother, it is not a 'part' of the mother in

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[15] The fetus lived for "ten or fifteen minutes" after premature birth. *Dietrich*, 138 Mass. at 15. Nevertheless, the court referred to the newborn as an "unborn child." *Id.* at 17

> the sence of a constituent element — as that term is generally understood. Modern medicine is replete with cases of living children being taken from dead mothers. Indeed, apart from viability, a non-viable foetus is not a part of its mother.

Id. at 140. As to the difficulty of proof of such claims, the court stated: "The law is presumed to keep pace with the sciences and medical science certainly has made progress since 1884. We are concerned here only with the right and not its implementation." *Id.* at 143.

Since *Bonbrest*, every state has recognized prenatal harm as a legitimate cause of action for a child subsequently born. *Prosser and Keeton on the Law of Torts* 368 (W. Keeton ed. 5th ed. 1984). Compensation for prenatal injuries has also been allowed under the Federal Tort Claims Act in an action against the United States. *Sox v. United States*, 187 F. Supp. 465 (E.D.S.C. 1960). A cause of action for prenatal injuries under 42 U.S.C. Sec. 1983 (1976) was recognized in *Douglas v. Town of Hartford*, 542 F. Supp. 1267 (D. Conn. 1982). The Court held that, for purposes of Sec. 1983, a fetus was a "person" within the meaning of the statute. *Contra*, *Harman v. Daniels*, 525 F. Supp. 798 (W.D. Va. 1981)(decided on virtually identical facts); *Poole v. Endsley*, 371 F. Supp. 1379 (N.D. Fla. 1974), *aff'd in part*, 516 F.2d 898 (5th Cir. 1975); *McGarvey v. Magee-Womens Hosp.*, 340 F. Supp. 751 (W.D. Pa. 1972), *aff'd*, 474 F.2d 1339 (3rd Cir. 1973). *See generally*, Note, *Douglas v. Town of Hartford: The Fetus as Plaintiff Under Section 1983*, *35 Ala. L. Rev. 397 (1984)*; Note, *The Fetus Under Section 1983: Still Struggling for Recognition*, 34 Syracuse L. Rev. 1029 (1983). Some states limit recovery to post-viability injuries, but the clear trend is toward recovery for all prenatal harm. *Prosser and Keeton*, *supra*, at 368-369; Note, *The Law and the Unborn Child: The Legal and Logical Inconsistencies*, 46 Notre Dame L. Rev. 349, 357 (1970).

The justifications given for discarding the viability test vary. In *Smith v. Brennan*, 31 N.J. 353, 157 A.2d 497 (1960), the New Jersey Supreme Court found that age is not the only determinant of viability, and, in borderline cases, there is no principled way to determine viability. *Id.* at 367, 157 A.2d at 504. The court said:

> We see no reason for denying recovery for a prenatal injury because it occurred before the infant was capable of separate existence. Whether viable or not at the time of the injury, the child sustains the same harm after birth and therefore, should be given the same opportunity for redress.

Id. A New York appellate court in *Kelly v. Gregory*, 282 A.D. 542, 125 N.Y.S.2d 696 (1953) (the first court to reject the viability standard) focused on the issue of biological separability: "[L]egal separability should begin where there is biological separability." *Id.* at 543, 125 N.Y.S.2d at 697. Here, as in other related areas of the law, medical science empowered the engine for legal change. The court noted such knowledge, especially that dealing with fetal development, as a factor in helping to lead to this rule. *Id.* at 543-44, 125 N.Y.S.2d at 697-98.

The Supreme Court of Rhode Island has dropped the viability test in favor of a causation test: "With us the test will not be viability but causation, and our inquiry will be whether the damage sustained is traceable to the wrongful act of another." *Sylvia v. Gobeille*, 101 R.I. 76, 79, 220 A.2d 222, 224 (1966). This causation test seems more rational and logical than a viability test, which has been criticized as arbitrary and transient. *See, e.g.*, Morrison, *Torts Involving the Unborn — A Limited Cosmology*, 31 Baylor L. Rev. 131, 141-144 (1979); Robertson, *Toward Rational Boundaries of Tort Liability for Injury to the Unborn: Prenatal Injuries, Preconception Injuries and Wrongful Life*, 1978 Duke L.J. 1401, 1414-1420. The disallowance of claims for injuries in the first trimester may well be the denial of the most meritorious and seriously harmful claims. Gordon, *The Unborn Plaintiff*, 63 Mich. L. Rev. 579, 589 (1965). Though causation may be difficult to

determine, most courts seem to realize that such difficulty should not be a bar to the action, but something to be handled in the courtroom. Recent medical advances make proof of medical causation increasingly reliable.

Roe and its analysis stands in stark contrast to the recognition of fetal rights in other areas of the law. Although some courts have utilized *Roe* to deny fetal rights, most courts have rejected the *Roe* rationale in order to affirm the personhood and legal rights of unborn persons in areas not involving abortion rights, and thus not burdened by the *Roe* Court's abortion distortion. In this way *Roe v. Wade* continues to be a positive detriment to coherence and consistency in the law.

C. *ROE V. WADE* IS OUTDATED AND IS INCONSISTENT WITH THE SENSE OF JUSTICE AND THE SOCIAL WELFARE.

The third test in *Patterson* to determine when a decision should be reconsidered is whether the precedent has become "outdated" and, after being "tested by experience, has been found to be inconsistent with the sense of justice or with the social welfare." *Patterson*, 109 S.Ct. at 2371. Many of the foregoing arguments could be reiterated in regard to *Roe* as an outdated doctrine. In addition to those arguments, there are five illustrations of this inconsistency: (1) the rejection of *Roe* in scholarly analysis and political activity; (2) the use of *Roe*, in practice and in law, to justify discrimination against the unborn in general, and those with disabilities in particular; (3) sex selection abortions; (4) the fetus as patient; (5) public opinion against abortion on demand; and (6) abortion as the exception which swallows all rules.

First, the inconsistency of *Roe* with the sense of justice and social welfare is illustrated by the political activity, scholarly analysis, and public opinion which rejects *Roe* as settled law. Since *Roe*, nearly 900 separately numbered resolutions relating to abortion have been introduced into Congress.[16] Over 300 are joint resolutions seeking Constitutional amendments that would overturn *Roe*.[17] Congress has also acted broadly to remove direct federal financial support for abortion.[18] Moreover, a 1988 Presidential proclamation declared the unborn to be protected under the Constitution, and directed the executive branch to carry out actions and programs consistent with that declaration.[19]

The strongest evidence of a popular rejection of the abortion right created in *Roe* is seen in the vast number of state legislative actions and public referenda designed to limit or regulate the performance of abortions. During the 1988 elections, public referenda in Michigan, Arkansas, and Colorado affirmed restrictions on abortion, and in Arkansas, granted rights to the unborn under the state constitution.[20] During the years since *Roe*, state legislatures from all regions have enacted hundreds of laws regulating abortion.[21] At least 23 state legislatures have sent memorials requesting Congress to propose an anti-abortion amendment to the Constitution, and 19 state legisla-

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[16] Wardle, *Rethinking Roe v. Wade*, 1985 B.Y.U.L. Rev. 231, 247, *citing*, Legal Ramifications of the Human Life Amendment: Hearings before the Subcomm. on the Constitution of the Senate Comm. on the Judiciary on S.J. Res. 3, 98th Cong. 1st Sess. 47, 73-74, App. B (1983) (prepared statement of Lynn D. Wardle) (600 resolutions, 1973-1985). Since 1985, over 300 more resolutions have been introduced. See Statistics prepared by Legislative Information Service, United States Senate, as of February 10, 1989.

[17] *See* Wardle, *supra* note 16, at 247-248, n.86, 270 (1973-85).

[18] *Harris v. McRae*, 448 U.S. 297 (1980); *Bowen v. Kendrick*, 108 S.Ct. 2562 (1988). *See also*, 42 U.S.C. Sec. 1396 et seq. (1982 ed. and Supp. IV) ("Hyde Amendment" restricting Medicaid funding of abortion); 42 U.S.C. Sec. 300-300a-6a (1982 ed. and Supp. IV); 42 U.S.C. Sec. 300z *et seq.* (1984) (Adolescent Family Life Act).

[19] Proclamation No. 5761, 53 Fed. Reg. 1464 (1988).

[20] Wash. Post, Nov. 13, 1988, at C6, col. 1.

[21] Bush, *Fertility-Related State Laws Enacted in 1982*, 15 Fam. Plan. Persp. 111, 111 (Table 1) (1983). Wardle, *supra* note 16, at 247 n.83.

tures have passed petitions to convene a constitutional convention to propose a human life amendment to the Constitution.[22] The democratic branches of government, therefore, have not accepted or endorsed *Roe*.

In academic circles, few if any opinions of this Court have attracted the barrage of criticism levied at *Roe*.

> Rarely does the Supreme Court invite critical outrage as it did in *Roe* by offering so little explanation for a decision that requires so much. The stark inadequacy of the Court's attempt to justify its conclusions . . . suggests to some scholars that the Court, finding no justification at all in the Constitution, unabashedly usurped the legislative function. . . . Even some who approve of *Roe's* form of judicial review concede that the opinion itself is inscrutable.[23]

Nor has *Roe* exhausted its critics, for the stream of published criticism continues to this day.[24] *Roe* remains vulnerable because it was inherently flawed from the outset,[25] and because the error has compounded itself, as subsequent case law proves.

Second, *Roe* has encouraged discrimination against the unborn in general and those with disabilities in particular.

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[22] Wardle, supra note 16, at 247.

[23] Morgan, *Roe v. Wade and the Lessons of Pre-Roe Case Law*, 77 Mich. L. Rev. 1724, 1724 (1979) (footnotes omitted).

[24] *See, e.g.*, Bopp, *Will There Be a Constitutional Right to Abortion After the Reconsideration of Roe v Wade?*, 15 J CONTEMP. L. 131, 134, (1989) ("A consensus has developed that, whatever one thinks of the holding, the analysis was inadequate."); Bopp & Coleson, *supra* note 7; Wardle, *supra* note 16; Knicely, *The Thornburgh and Bowers Cases: Consequences for Roe v. Wade*, 56 Miss. L.J. 267, 281 (1986); Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 1985 N.C.L. Rev. 375; Note, *Technological Advances and Roe v. Wade: The Need to Rethink Abortion Law*, 29 U.C.L.A. L. Rev. 1195 (1982). While not all these articles suggest reversal of *Roe* as the solution, they illustrate the continued difficulty of adhering to *Roe's* standards.

[25] Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 Yale L.J. 920, 932, 935-936 (1973).

Discrimination against the unborn in general is illustrated by the reasons given by women who have secured abortions. Each year, since the late 1970s, approximately 30 percent of all pregnancies in the United States have ended in abortion (miscarriages excluded). Torres and Forrest, *Why Do Women Have Abortions?*, 20 Family Planning Perspectives 169, 169 (1988). In 1988, the Alan Guttmacher Institute published the results of a survey of abortion patients addressing the question of why women choose to have abortions. In all, 1,900 women responded to the questionaire with usable information. Most women cited more than one reason for aborting. The results show that 76 percent of the women were concerned about how a baby could change their lives, 68 percent felt they couldn't afford a baby now, 51 percent had problems with their relationship to the fathers or wanted to avoid single parenthood. *Id.* at 170. These are the percentages of women reporting that these reasons, respectively, were most important to them in deciding to abort. Only 7 percent of the women cited health problems (not necessarily life threatening), and only 1 percent cited rape or incest as the most important reason for aborting. *Id.*

From this information, it is clear that abortion, in practice, is used instead of birth control in the overwhelming majority of cases. Maternal health problems are at the bottom of the list. Social and economic problems, real or imaginary, are at the top of the list. Such invidious discrimination against human beings would not be tolerated elsewhere in the law. Yet this discrimination is the worst kind because it results in the death of those discriminated against. Causing the death of another human being, for less than grave reasons, violates our sense of justice.

Further, *Roe* has resulted in specific discrimination against unborn humans with disabilities. This result occurs due to the wave of wrongful birth/wrongful life causes of action recognized by various courts since *Roe*. Wrongful birth actions hold physicians and other health care professionals liable for failure to test for birth defects and to advise the parents that they could abort the child, if the child tests positive. The parents claim

that they would have aborted the child if they had been properly advised. Bopp, Bostrom & McKinney, *The "Rights" and "Wrongs" of Wrongful Birth and Wrongful Life: A Jurisprudential Analysis of Birth Related Torts*, 27 Duq. L. Rev. 461, 461-62 (1989). Wrongful life actions are similar, except that the action is brought by a child with disabilities, who claims that his life is wrongful since his parents were denied their right to abort him. *Id.*

Prior to the 1973 decision in *Roe*, wrongful birth/life actions were unsuccessful due to the prevailing public policy against abortion. *Id.* at 467. With the *Roe* Court's enunciation of a woman's privacy right which protected the abortion decision from state criminal prosecution, wrongful birth claims were recognized by some courts on the theory that the negligence of the health care provider had infringed this private, protected choice. Commentators are nearly unanimous in concluding that *Roe* provided the legal springboard for the wave of wrongful birth actions that subsequently appeared. This conclusion is supported by the language and citations to *Roe* found in the decisions which recognized the new cause of action. *Id.*

One of the most important results of holding physicians and others liable for failure to advise of the presence or possibility of birth defects is that they are forced to practice "defensive" medicine. Such potential liability creates a financial incentive for physicians to recommend amniocentesis and genetic screening in borderline cases, and in possibly most or all cases for the particularly cautious physician. An increase in prenatal testing in turn results in more abortions, both of nondisabled fetuses because of false postitive test results, and fetuses with disabilities (the extent of which are frequently unknown and unpredictable) because the fetus does not meet the couples standard of perfection. *Id.* at 485-92.

This *Roe*-engendered discrimination against fetuses with disabilities stands in stark contrast with public policy regarding such persons after birth. State public policies are commonly protective of persons with disabilities regarding the

provision of health insurance and education programs. *Id.* at 494. Federal policy likewise encourages the care and education of persons with disabilities as reflected in the Education of the Handicapped Act, 20 U.S.C.A. Sec. 1400-85 (West Supp. 1988), the Child Abuse Amendment of 1984, 42 U.S.C.A. Sec. 5101-03 (West Supp. 1988), the provision of grants to states that offer free public education to disabled children, 20 U.S.C.A. 2771-72 (West Supp. 1988), and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C.A. Sec. 794 (West. Supp. 1988).

Against the backdrop of policy protecting citizens with disabilities, recognition of wrongful birth/life claims creates a jurisprudential contradiction: a legal system that at once encourages the destruction of "defectives" before birth and seeks to protect those lives after birth. Rosenblum & Grant, *The Legal Response to Babies Doe: An Analytical Prognosis*, 1 Issues in Law & Med. 391 (1986). This result, traceable directly to *Roe*, is inconsistent with the sense of justice and the social welfare.

Third, another illustration of how *Roe* is inconsistent with the sense of justice and social welfare is the rise of sex selection abortions. "There are no national data on the number of prenatal diagnoses done for sex selection, nor on the number of women who terminate pregnancies because of the sex of the fetus. But every one of more than a dozen geneticists interviewed said they regularly receive requests for prenatal diagnosis for sex selection." Kolata, *Fetal Sex Test Used as Step to Abortion*, The New York Times, Dec. 25, 1988, at A1.

On the one hand, a recent survey found that 34% of 295 United States geneticists surveyed would perform prenatal diagnosis for sex selection abortions and 28% would refer couples to someone who would perform it. *Ethics and Medical Genetics in the United States: A National Survey*, 29 Am. J. Med. Genetics 815 (1988)(cited in Wertz & Fletcher, *Fatal Knowledge? Prenatal Diagnosis and Sex Selection*, Hastings Center Rep., May/June 1989, at 21). On the other hand, a survey by the Boston Globe revealed that 93% of Americans think that

sex selection abortions should be illegal. *Most in U.S. Favor Ban on Majority of Abortions, Poll Finds* The Boston Globe, Mar. 31, 1989, at A1.

This type of selection process is not dissimilar to shopping for goods in order to find the desired size, shape and color. If sex selection abortions are consistent with the sense of justice and the social welfare, why not selection for eye or hair color, height or weight. If fetuses are not human lives, are they merely goods to be thrown away if failing to meet some predetermined set of arbitrary quality standards? This amounts to consumer genetics, an extreme devaluation of human life.

Fourth, in stark contrast to the consumerist view is the modern view of the fetus as patient. In the last few decades medical technology has advanced to the the point where visualizing, monitoring and measuring fetal activity is possible. Lenow, *The Fetus as a Patient: Emerging Rights as a Person?*, 9 Am. J. L. & Med. 1, 15-16 (1983). Due to these advances, the fetus is not only capable of being monitored, but treated by physicians for certain conditions prior to birth. Treatments include medicines administered orally to the mother, or directly into the amniotic fluid, as well as fetal surgery. Surgery can take place entirely within the uterus or after partial removal of the fetus from the uterus onto an open operating field. *Id.* at 16-17. Such advances in medical procedure and care given to unborn humans in need of medical treatment represents a sense of justice and social welfare lost in abortion on demand.

Fifth, prior to *Webster* it seemed that abortion jurisprudence had evolved into a right to abort without limitations. This occurred despite public opinion to the contrary. In a survey by The Boston Globe/WBZ, the following percentages of persons polled wanted abortion to be illegal in the respective circumstances: when the woman is a minor- 50%, wrong time in life to have a child- 82%, fetus is not the desired sex- 93%, financial difficulties- 75%, as a means of birth control- 89%, emotional strain- 64%, father unwilling to help raise the child- 83%, father

absent- 81%, mother wants abortion, father wants baby- 72%, and father wants abortion, mother wants baby- 75%. *Most in U.S. Favor Ban on Majority of Abortions, Poll Finds*, The Boston Globe, Mar. 31, 1989, at A1. Thus, for most of the reasons commonly given by women seeking abortions, *Roe*, as expanded by its progeny, is inconsistent with the public sense of justice and social welfare.

Sixth, *Roe* and its progeny are also inconsistent with the sense of justice and social welfare as revealed by the abortion distortion factor. *Roe* became the exception which swallows all rules in the sense that limitations common to other areas of the law were struck down where abortion was concerned. For example, in Justice Burger's dissent in *Thornburgh v. American Coll. of Obst.*, 476 U.S. 785 (1986), he states: "In short, every Member of the *Roe* Court rejected the idea of abortion on demand. The Court's opinion today, however, plainly undermines that important principle, and I regretfully conclude that some of the concerns of the dissenting Justices in *Roe*, as well as the concerns I expressed in my separate opinion, have now been realized." *Id.* at 782-83 (Burger, J., dissenting).

The examples cited by Justice Burger included the requirement of informed consent in the interest of protecting maternal health, *id.* at 783, in the requirement of a second doctor in order to protect the "potentiality of human life," *id.* at 784, and in the requirement of parental consent or court authorization for minors to receive abortions. *Id.* at 785. Thus, prior to *Webster*, *Roe* seemed to create an constitutional right to abortion which could not be limited in any reasonable fashion.

For all the above reasons, it may be concluded that reconsideration of *Roe* is required, because *Roe* is outdated, and is inconsistent with the sense of justice and the social welfare.

II. *ROE V. WADE* SHOULD BE REVERSED.

The reasons cited for reconsideration of *Roe* also stand in support of its reversal. The tangent set by *Roe's* unconstitutional departure from the norm has led abortion jurisprudence

far from the path of the rest of the law. A correction in the angle of the trajectory is required. The most direct and constitutionally defensible correction is the reversal of *Roe*.

As recently as 1985, Justice Blackmun, author of *Roe*, declared that "when it has become apparent that a prior decision has departed from a proper understanding" of the Constitution, the prior decision must be overruled. *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 557 (1985). A Supreme Court refusal to overrule *Roe v. Wade* merely because it is claimed to be entrenched would be the ultimate illustration of the super-protected nature of the abortion right.

CONCLUSION

The three tests and sub-tests set out in *Patterson* for the reconsideration of a precedent are each and all met in *Roe v. Wade*, although only one test need be met. *Roe*, therefore, is thrice qualified for reconsideration. There is no merit in delaying it.

Wherefore, for the above reasons, these Amici respectfully request the Court to reconsider and, upon reconsideration, reverse *Roe v. Wade*.

Respectfully submitted,

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AMICUS CURIAE

BRIEF

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No. 88-790

IN THE
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October Term, 1989

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et al.,.....Appellants,

versus

RICHARD M. RAGSDALE, M.D.,
et al.,.....Appellees.

ON APPEAL FROM THE UNITED STATES COURT
OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF OF KAREN K. BOVIK, PH.D., SPEAKING FOR THE VOICELESS: THE MORAL GROUND OF CONSTITUTIONAL LAW IN TURNOCK V. RAGSDALE, AS AMICI CURIAE IN SUPPORT OF APPELLANTS.

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES iii

STATEMENT OF INTEREST OF AMICAS CURIAE 1

INTRODUCTORY STATEMENT 2

The Moral Ground of Law: The Will of the United States Constitution 2

SUMMARY OF THE ARGUMENT 3

Moral Value as a Basis for Law 3

Webster v. Reproductive Health Services 4

Turnock v. Ragsdale 5

Life, Liberty, and the Pursuit of Happiness 5

Evidence for the Moral Stand Supporting Turnock 5

ARGUMENT 6

Abortion Issues: The will of the law 6

Constitutional Issues

1. Fundamental Rights 6
2. Due Process 6
3. Privacy 7
4. Theory of Life 7

Page

5. Self Defense 7

6. Rape 7

Concrete Issues 8

7. Health 8

8. Viability 8

9. Child Abuse 9

Moral Argument: Basis for law ... 9

10. Right to Abortion 9

11. Religion 9

12. Feminist 10

13. Choice and Crisis 10

CONCLUSION 11

TABLE OF AUTHORITIES

CASES **PAGE**

Webster v. Reproductive Health Services, 109 SCt. 1635 (1989). 3, 4, 5, 8

Roe v. Wade., 410 U.S. 179 (2d Cir. 1973) . . . . . 3, 6, 7 ,9, 11

STATUTES

Mo. Rev. Stat. 1(1), 2(1986) 7, 9

MISCELLANEOUS

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The United States Law Week, Extra Edition No. 2, Volume 57, No. 50 June 27, 1989 . . . . . 3, 4 ,7, 9, 10

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STATEMENT OF INTEREST OF AMICAS CURIAE

This brief is filed with the parties' written consent.

This author, Karen K. Bovik, Ph.D., has been an activist and an advocate. Dr. Bovik has been involved with civil rights issues since 1963, participating with the Illinois Interracial Council, and

currently has a personal Christian ministry serving the low-income and disadvantaged in Wood County, Ohio, the State of Ohio, and on a Federal level in areas of workfare, housing, education, and health issues. The author researched, organized, and was project director for a food program serving this low-income population. This author has an earned Doctor of Philosophy and has done research on moral values and public policy, utilizing Bovik Integrated Values Analysis. The author has been active with the Right to Life movement; associates with Students for Life at Bowling Green State University, Bowling Green, Onio, as well as other Right to Life groups.

INTRODUCTORY STATEMENT

The Moral Ground of Law: The will of the United States Constitution. *Turnock v. Ragsdale*, #88-790.

In *Turnock v. Ragsdale*, the State's right to oversee and regulate health care is the predominate concern. This appears to be an obvious responsibility of the Sovereign State.

Within the jurisdiction of the United States Supreme Court are more basic questions to civil rights issues. While moral and religious arguments have been thrown out as inappropriate, they are at the heart of the Constitution. They are in fact the basis of the Constitution. Therefore, anytime the issue of abortion comes before the Court, the ground of the arguments concerning abortion are appropriate to consider.

SUMMARY OF THE ARGUMENT

Constitutional Law requires interpretation. Neither the willy-nilly 'will of the people' (Scalia, Law Week, 57lw5034, 6-27-89) nor the will of any ideological or moral viewpoint, which has as a ground a contrary purpose, therefore, is an acceptable base for understanding the points of the law. The purpose of the United States Constitution is for both individual liberty and common good, and it has a moral ground. It is a moral document. All law is based on morality and has jurisdiction. If it please the court, consider the arguments herein which are presented to this honorable court.

The issue of the protection and respect for life can be inferred or assumed in the United States Constitution as a *sine qua non*; a minimum standard without which there can be nothing. Or in the case of abortion, 'without life, nothing.' The ground of an argument cannot be ignored. It appears that United States Supreme Court Justice Scalia alluded to this issue with his pointed remarks concerning overturning *Roe v. Wade*, 410 U.S. 179 (2d Cir. 1973), in his comments at the time of the *Webster v. Reproductive Health Services*, 109 SCt. 1635 (1989) decision (Law Week, 57LW5034, 6-27-89).

Moral value is the basis for law.

As a primary personal moral value, I believe that protection for human life is a *sine qua non*. The Constitution of the United States implicitly provides this. Thus, personal moral value and

public moral value is at the basis for all law!

The very reason for all criminal law is this value for the protection of human life. This is why the most severe penalties exist where there is wrongful death. This value is inferred, implied, and in criminal law this value is acted upon by the State.

The honorable Supreme Court Justices Blackmun, Brennan, Marshall, and Stevens (Law Week, 57LW 5035), appear to be throwing out moral arguments by summarily dismissing them as religious viewpoints. Yet, the basis for all Constitutional Law is morality.

This is true for life and death concerns, civil rights, and common sense health concerns such as in *Turnock v. Ragsdale*. The appellants, Turnock, in this case, are demonstrating a reasonable, responsible, and moral concern for health, at least for one of the patients.

Self-defense, privacy, choice, crisis pregnancies, what defines murder, and due process, are issues for consideration in determining the rights of the baby and the rights of the mother as human beings.

<u>*Webster v. Reproductive Health Services*</u>

Webster v. Reproductive Health Services, 109 SCt. 1635 (1989) demonstrated that the United States Supreme Court does not value abortion over childbirth (Chief Justice, Law Week, 57LW5024, 6-27-89). Yet, the ground of the argument, the point of outrage, was basically ignored. <u>The ground of all law is morality</u>.

In the dissenting opinions in *Webster v. Reproductive Health Services*, 109 SCt. 1635 (1989), Section 188.029, there was a developmental argument concerning who is considered worthy of protection under the law. Sometimes the dissenters consider people expendable by using a different rhetorical label to identify their stage of development, and thereby remove legal protection for their lives.

Turnock v. Ragsdale

In *Turnock v. Ragsdale* the ground of the argument and basis for law is very important. *Turnock v. Ragsdale* deals with secondary issues which gloss over and hide the serious underlying legal Constitutional issues of the civil rights of all human beings: the right to life, liberty and the pursuit of happiness, due process in termination of life, the right to a jury trial before a death sentence or any legally supported punishment, and no cruel or unusual punishment.

Life, Liberty, and the Pursuit of Happiness.

Whether or not anyone is loved or wanted should not be a Constitutional issue. Human beings in the United States of America have a right to life, liberty and the pursuit of happiness! They have no right to happiness, only the right 'TO PURSUE' happiness.

Evidence for the supporting *Turnock*

While the concern for adequate medical standards is worthy of applause, the foundation of an argument must be on solid ground. Obviously the language of *Turnock* only points to medical

concerns of the mother. The correct foundation of this argument should be a concern for the health of both patients: mother and child.

In *Turnock v. Ragsdale* it would appear to be a clear issue. When would the United States Supreme Court say that women could be treated with less than high quality health standard? Of course it stands to reason that if any medical procedure is considered legal that the best quality health care should be given. It seems self-evident that cheap is not the first moral and legal consideration.

Legally, if it is known that someone is human and alive, and it is recognized that there is a human individual who has his or her own physical identity, DNA, fingerprint, blood, species and other identifying factors, then the intentional taking of such human life without due process, not in self-defense, not accidental, is called murder in the first degree.

ARGUMENT

Abortion Issues: The will of the law

Constitutional Issues

1. Fundamental Rights: Direct wording is 'the right to life.'

2. Due process: The one person who is denied civil rights in the case of abortion is the human being in the womb. Civil rights can not be denied because an individual is dependent or inconvenient. Now, this human being in the womb is being denied due process by *Roe v. Wade*, 410 U.S. 179 (2d Cir.

1973).

3. Privacy: The right to privacy, is a contrived right, and misused as an abuse of liberty. What true privacy does any of us have? Justices Blackmun, Brennan, Marshall, and Stevens, as reported in Law Week (57LW5038, 6-27-89) agree "It is this general principle, the 'moral fact that a person belongs to himself and not others nor to society as a whole (quoting Fried).'" Yet, abortion on demand says that a baby in the womb belongs to the mother, and she can give consent to kill this human being who has a different DNA, blood, flesh, and is a human being by species. *Roe v. Wade*, 410 U.S. 179 (2d Cir. 1973), and subsequent cases.

4. Theory of life: Mo. Rev. stat. 1.205.1(1), (2) (1986). By using the word theory, the law insinuates itself into the most primary of all concerns. *Roe v. Wade*, 410 U.S. 179 (2d Cir. 1973). Life is not academic—it is. If no one interferes with that fetus, it can reasonably be expected that a baby will be born who is a human being. Do not interfere with life. Let it be.

5. Self-defense: Maternal health versus babies' health is not a new issue. It should be based only on physical threat. This concept of self defense should not invite licentious behavior. Killing a human being who is dependent or inconvenient is not excused by the self-defense justification.

6. Rape: The human being in the womb did NOT

rape anyone.

Concrete Issues

7. Health: The health of all patients should be considered. A human being in the womb is given great medical consideration, given the baby's right to life has been affirmed by the mother. The Court's recent decisions since 1973 have left the choice up to the mother, according to her attitude toward the child. This is governance by man, not law. Attitudes are changeable, and passion is not good ground for building a civil society. In *Turnock v. Ragsdale* #88-790, only the mother's health is being considered. While it is vital for any 'medical procedure' to be accomplished in a responsible manner, this should include a concern for the morality of the procedure as well as the implementation of the procedure.

8. Viability: Section 188.029 of *Webster v. Reproductive Health Services*, 109 SCt. 1635 (1989) is concerned with viability. This is a development argument which is in error. A human being is always a human being. There is not one point in the life of a species that it changes species. A dog is a dog, *Canis*, a cat is a cat, *Felis*, a human being is always a human being, *Homo sapiens*. Always. Yes, there are descriptors such as old, young (fetus, infant), voiceless, orphan, hated, loved, wanted, ugly, handicapped and many others. But descriptors equate to qualifying for the sake of recognition, not to defining out value or rights. This also relates to the theory of life

issue: Mo. Rev. stat. 1.205.1 (1), (2) (1986).

9. Child Abuse: Mothers are being punished by law for cocaine use while pregnant. Yet a mother can agree to kill her baby in the womb and this is considered legal. Either that human being in the womb is protected by law or it is not. This is disintegrated reasoning: to protect or kill by reason of attitude, not by law, which is an abrogation of civil rights, such as due process.

Moral Argument: Basis for Law

10. Right to Abortion: Justices Blackmun, Brennan, and Marshall in Law Week, 57LW5035, 6-27-89 agree to the term life directing.' This is a misleading notion. Our rights to life, liberty, and the pursuit of happiness do not also agree that these rights are at any cost. We can give our life for our country and others, but we cannot take the life of another. If the law agrees not to interfere in the pregnancy and keeps others from interfering with that life, there will be a human baby born.

There should be no law which interferes with that life, which is a separate individual from the mother. All of us started the same way, in the womb as a fertilized egg. Not an egg, not a sperm, but as the little male or female offspring. No one had the right to abort us when we were in the womb, prior to *Roe v. Wade*, 410 U.S. 179 (2d Cir. 1973).

11. Religion: A contrived issue of the ideological left. By

calling moral arguments 'religious' it enables them to throw out serious moral points of law (Blackmun, Brennan, Marshall, and Stevens in Law Week, 57LW5039, 6-27-89). The law is based on morals.

12. Feminist: As a woman I cannot agree that a woman should have the right to agree to have her baby killed. The baby is not chattel. The womb is not a killing field. The word *womb* has been associated with nurture. The rights of female babies are ignored. About 50% of those births, if the law supported birth, would be female human beings.

13. Choice and Crisis. Many women probably are frightened and confused about being pregnant. That is a reason to help the women through their personal crisis. "It is not a reason to turn a womb into a tomb."

Some individuals might think they are doing the mother a favor to engineer an abortion. They are not. They are killing some one else's child. When the momentary distress leaves, the realization of the loss will eventually become conscious.

If it is known that there is human individual life, then the law should regard that life as human individual life. This would include both male and female, healthy and not so healthy, of any race, of any religious background, according to civil rights. If the ground of an argument is not being considered, then the ground of an argument should become priority.

CONCLUSION

I pray that the Court look at the moral ground of the primary issue: abortion. I pray that the Court make clear the rights established by the Constitution: those of the Right to Life, Liberty, and the Pursuit of Happiness, with appropriate qualifications of due process and self-defense. I pray that ther Court seek justice with mercy for all individuals involved. Please reverse *Roe v. Wade*, 410 U.S. 179 (2d Cir. 1973), and return civil rights to all individuals under the law. If the Court in her wisdom decides not to reverse *Roe v. Wade*, 410 U.S. 179 (2d Cir. 1973), then all Sovereign States should have the right to protect the health of individuals through standard regulations.

Respectfully Submitted:

Karen Bovik, B.S., M.A., M.A., Ph.D.

Dated: 8-29-89

Submitted to Court: 8-31-89